DOCKET

SUPREME COURT
OF THE UNITED STATES

No. 12-98
Title: Aldona Wos, Secretary, North Carolina Department of Health and Human Services, Petitioner
v.
E. M. A., a Minor, By and Through Her Guardian ad Litem, Daniel H. Johnson, et al.
Docketed: July 24, 2012
Linked with 11A1171
Lower Ct: United States Court of Appeals for the Fourth Circuit
Case Nos.: (10-1865)
Decision Date: March 22, 2012
Questions Presented

~~Date~~~	~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~
Jun 7 2012	Application (11A1171) to extend the time to file a petition for a writ of certiorari from June 20, 2012 to July 20, 2012, submitted to The Chief Justice.
Jun 14 2012	Application (11A1171) granted by The Chief Justice extending the time to file until July 20, 2012.
Jul 20 2012	Petition for a writ of certiorari filed. (Response due August 23, 2012)
Aug 23 2012	Brief of respondents E. M. A., a Minor, By and Through Her Guardian ad Litem, Daniel H. Johnson, et al. in opposition filed.
Sep 4 2012	Reply of petitioner Albert A. Delia, Secretary, North Carolina Department of Health and Human Services filed.
Sep 5 2012	DISTRIBUTED for Conference of September 24, 2012.
Sep 25 2012	Petition GRANTED.
Oct 31 2012	SET FOR ARGUMENT ON Tuesday, January 8, 2013.
Nov 9 2012	Joint appendix filed. (statement of costs received)
Nov 9 2012	Brief of petitioner Albert A. Delia, Secretary, North Carolina Department of Health and Human Services filed.
Nov 15 2012	Record received from U.S.C.A. for 4th Circuit. (1 envelope)
Nov 16 2012	CIRCULATED.
Nov 16 2012	Brief amicus curiae of National Governors Association filed. (Distributed)
Nov 16 2012	Brief amici curiae of Texas, et al. filed. (Distributed)
Dec 10 2012	Brief of respondents E. M. A., a Minor, By and Through Her Guardian ad Litem, Daniel H. Johnson, et al. filed. (Distributed)
Dec 10 2012	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.

Dec 17 2012	Brief amicus curiae of the United States filed. (Distributed)
Dec 17 2012	Brief amicus curiae of Federation of Defense and Corporate Counsel filed. (Distributed)
Dec 17 2012	Brief amici curiae of American Association for Justice, et al. filed. (Distributed)
Dec 17 2012	Brief amici curiae of AARP, et al. filed. (Distributed)
Dec 28 2012	Reply of petitioner Albert A. Delia, Secretary, North Carolina Department of Health and Human Services filed. (Distributed)
Jan 4 2013	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
Jan 8 2013	Argued. For petitioner: John F. Maddrey, Solicitor General, Raleigh, N. C. For respondents: Christopher G. Browning, Jr., Raleigh, N. C.; and Ginger D. Anders, Assistant to the Solicitor General, Department of Justice, Washington, D. C. (for United States, as amicus curiae.)

PETITION FOR WRIT OF CERTIORARI

RECORD AND BRIEFS

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No. _____

Supreme Court, U.S.
FILED
JUL 20 2012
OFFICE OF THE CLERK

In the
Supreme Court of the United States

ALBERT A. DELIA, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

E.M.A., a Minor, by and through her Guardian ad Litem, DANIEL H. JOHNSON, WILLIAM EARL ARMSTRONG and SANDRA ARMSTRONG,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

PETITION FOR WRIT OF CERTIORARI

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July 2012

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QUESTION PRESENTED

The Medicaid Act requires participating States to seek reimbursement from third-party tortfeasors for health-care expenditures they made to Medicaid recipients who are tort victims. 42 U.S.C. §§ 1396a(a)(25), 1396k(a) (2006). To enforce that requirement when the recipient and a third-party resolve their tort dispute through judgment or settlement, North Carolina law provides that the State has a subrogation right to, and may assert a lien upon, the lesser of one-third of the recipient's recovery or the State's actual medical expenditures. N.C. Gen. Stat. § 108A-57 (2011).

The question presented is whether N.C. Gen. Stat. § 108A-57 is preempted by the Medicaid Act's anti-lien provision as it was construed in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), an issue on which the North Carolina Supreme Court and the United States Court of Appeals for the Fourth Circuit are in conflict.

LIST OF PARTIES TO THE PROCEEDING BELOW

Appellants listed by the court below were E.M.A., a minor, by and through her Guardian ad Litem, William W. Plyler, William Earl Armstrong and Sandra Armstrong. By Order filed May 18, 2012, the United States District Court of the Western District of North Carolina substituted Daniel Johnson for William W. Plyler as the Guardian ad Litem.

Appellee below was Lanier M. Cansler, in his official capacity as Secretary of the North Carolina Department of Health and Human Services. The current Acting Secretary of the North Carolina Department of Health and Human Services is Albert A. Delia. By Order filed May 29, 2012, the United States District Court of the Western District of North Carolina modified the caption of the case below to reflect the substitution.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit (Pet. App. 1a-70a) is reported at 674 F.3d 290. The opinion of the United States District Court for the Western District of North Carolina (Pet. App. 70a-85a) is reported at 722 F. Supp. 2d 653.

JURISDICTION

The judgment of the United States Court of Appeals for the Fourth Circuit was entered on March 22, 2012. (Pet. App. 1a-70a) On June 14, 2012, the Chief Justice extended the time within which to file a petition for writ of certiorari to and including July 20, 2012. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant provisions are reprinted in an appendix to this petition. (Pet. App. 114a-123a)

STATEMENT

The Medicaid Act imposes two seemingly conflicting requirements upon the States. On the one hand, it requires States to seek reimbursement from third-party tortfeasors for health-care expenditures the States made to tort victims by requiring States to enact assignment laws under which recipients, as a condition to receiving Medicaid, assign to the State any rights they have to payment for medical care from third parties. On the other hand, the Medicaid Act's anti-lien provisions bar States from placing liens

against, and seeking recovery of benefits paid from, a Medicaid recipient.

In *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), this Court interpreted the Medicaid Act in the context of Arkansas' effort to claim a portion of the proceeds of a settlement between a Medicaid recipient and the tortfeasor. Arkansas had stipulated that only one-sixth of the settlement proceeds were payments for medical expenses, but it later sought recovery of its entire Medicaid payment. The Court held that the anti-lien provisions, when read in conjunction with the reimbursement provisions, permitted Arkansas to recover only the portion of the settlement that represented medical expenses.

Neither the Medicaid Act nor the decision in *Ahlborn*, however, specifies how a State should determine what portion of a personal injury damage settlement represents reimbursement for medical expenses. *Ahlborn* recognized that States may have "special rules and procedures for allocating tort settlements," but ultimately "express[ed] no view on the matter" and "le[ft] open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation." *Id.* at 288 n.18. Additionally, while noting that the issue was not squarely before it, the decision acknowledged that one way to avoid manipulation of a settlement by the Medicaid recipient was to obtain the State's advance agreement to an allocation. *Id.* at 288. This case

squarely presents issues that *Ahlborn* left unaddressed.

North Carolina has adopted special rules and procedures for allocating tort settlements when it has paid for medical services for the injured party through its Medicaid program. The relevant statutes provide that the medical expenses component of these settlements equal one-third of the recovery or the amount paid by the Medicaid program on behalf of the recipient, whichever is less. These statutes authorize a reduction of the State's claim to one-third of the recovery when the Medicaid claim would otherwise exceed that amount. N.C. Gen. Stat. § 108A-57 (2011) (Pet. App. 114a-115a); § 108A-59 (2011) (Pet. App. 116a-117a). North Carolina's statutory scheme provides advance guidance to Medicaid recipients and tortfeasors as to how they should address the medical expenses component in their settlement agreements. The State's consent to an allocation of the proceeds is conditioned upon the parties apportioning the settlement to include reimbursement for medical expenses consistent with the statutory provision.

In 2008, the North Carolina Supreme Court upheld North Carolina's statutory procedure, ruling that it was consistent with Medicaid's anti-lien provision as construed in *Ahlborn*. *Andrews v. Haygood*, 362 N.C. 599, 669 S.E. 2d 310 (2008), *cert. denied sub nom. Brown v. North Carolina Department of Health and Human Services*, 129 S. Ct. 2792 (2009) (Pet. App. 86a-113a). *Andrews* concluded that the North Carolina

law provides a reasonable method for determining "the medical expense portion of a settlement," one that "protects [the recipient's] interests while promoting efficiency in Medicaid reimbursement cases throughout North Carolina." (Pet. App. 96a) And in 2009, the federal Centers for Medicare & Medicaid Services ("CMS"), which administers the Medicaid program, stated that it agreed with the North Carolina Supreme Court's conclusion. (Pet. App. 139a-142a)

Here, however, the Fourth Circuit held that North Carolina's statutory procedure violates the Medicaid anti-lien provisions because it allows the State to take a one-third share of a settlement even where the settling parties may have desired to allocate less than one-third of the settlement to medical expenses. The Fourth Circuit ruled that under *Ahlborn* the amount of North Carolina's Medicaid lien "must be subject to adversarial testing" and that States may not statutorily determine how Medicaid beneficiaries must allocate their tort settlements. (Pet. App. 53a)

A. Statutory Background

North Carolina participates in the federal Medicaid program established by Title XIX of the Social Security Act, also known as the Medicaid Act, 42 U.S.C. § 1396 *et seq.* The Medicaid Act provides federal funding to North Carolina and other States to provide payments for medical assistance to qualifying needy individuals who are unable to afford their own medical costs. Funding is conditioned on the adoption of a State plan that complies with specific federal

requirements. 42 U.S.C. § 1396a (2006). The North Carolina Department of Health and Human Services ("DHHS") is the regulatory body charged with establishing and administering the State's Medicaid program. N.C. Gen. Stat. § 108A-54 (2011).

One of the conditions imposed by the federal government is known as the anti-lien law, 42 U.S.C. §§ 1396a(a)(18) (Pet. App. 118a) and 1396p (2006) (Pet. App. 123a), which prohibits states from attaching a lien to a Medicaid recipient's personal property. There is an exception to the anti-lien law for recoveries from third parties that are liable for payment of a recipient's medical expenses. Federal law requires that the State "take all reasonable measures to ascertain the liability of third parties" to pay for services covered by Medicaid and to "seek reimbursement . . . to the extent of such legal liability." 42 U.S.C. § 1396a(a)(25)(A)-(B) (2006).

The State must accomplish this by requiring Medicaid beneficiaries to assign the State their rights to third-party recoveries for medical expenses. 42 U.S.C. § 1396k (2006) (Pet. App. 120a-122a). These provisions are collectively known as the third-party recovery requirements. Congress has articulated the public policy evidenced in these laws: "Medicaid is intended to be the payor of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 99-146, at 312 (1985).

North Carolina has complied with its federally approved State Plan for Medical Assistance by enacting an assignment statute at N.C. Gen. Stat. § 108A-59, and a subrogation statute at N.C. Gen. Stat. § 108A-57. The assignment statute provides, as a condition of eligibility, that Medicaid recipients are "deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise, to which [the recipient] may be entitled." N.C. Gen. Stat. § 108A-59(a) (2011) (Pet. App. 116a). Implementation of the recipient's statutory assignment is governed by N.C. Gen. Stat. § 108A-57(a) (Pet. App. 114a-115a), which requires the attorney for the recipient to enforce the Medicaid program's subrogation rights. The amount of the Medicaid program's subrogated recovery is the lesser of one-third of the gross amount recovered from the third party or the amount paid by the Medicaid program for medical assistance to the recipient.

North Carolina's statutes therefore designate in advance an allocation of settlement proceeds between medical costs and other damages while capping the State's reimbursement at one-third of the total recovery even if the actual Medicaid payment for medical expenses is far greater.

B. Factual Background

The minor respondent sustained serious injuries at birth allegedly resulting from the negligence of the medical professionals who attended to her delivery. A medical malpractice action was brought in state court

on behalf of E.M.A. by her guardian ad litem and her parents which was eventually settled for a lump sum of approximately $2.8 million. Prior to agreeing to the settlement, the parties were on notice that DHHS had already paid more than $1.9 million for E.M.A.'s medical care. (Pet. App. 7a) The settlement agreement did not specifically allocate separate amounts for past medical expenses and other categories of damages. (Pet. App. 6a-8a)

Because the total medical payments of $1.9 million exceeded one-third of the total recovery, the DHHS claim was reduced pursuant to N.C. Gen. Stat. § 108A-57, resulting in a statutory lien on the settlement proceeds of $933,333.33 (one-third of the $2.8 million lump-sum settlement). The trial court ordered that amount paid into the registry of the state court, pending a determination of the State's lien. (Pet. App. 8a-9a)

C. Proceedings Below

Respondents brought an action in federal district court against Lanier M. Cansler, in his official capacity as Secretary of DHHS, seeking, among other things, that DHHS be enjoined from enforcing the North Carolina third-party recovery statutes. The district court granted summary judgment in favor of DHHS, holding that the North Carolina third-party liability provisions are consistent with the Medicaid Act's anti-lien provisions as construed in *Ahlborn*. (Pet. App. 71a-85a)

The district court distinguished *Ahlborn* by finding that the "Arkansas reimbursement statute [in *Ahlborn*] violated the federal anti-lien provision because it permitted the State to impose a lien beyond the portion of a settlement allocated to medical care." (Pet. App. 82a) By contrast, the North Carolina statute "provides a means of calculating that portion, and then forbids the State from imposing a lien on the remainder of the settlement." (Pet. App. 82a) The district court found the decision of the North Carolina Supreme Court in *Andrews* persuasive, noting that North Carolina's statute prevents a Medicaid recipient from suffering an "excessive depletion of a plaintiff's recovery to satisfy the State's reimbursement lien" because the recovery is capped at one-third of the total recovery. (Pet. App. 82a-83a)

The Fourth Circuit vacated the judgment of the district court, holding that North Carolina's statutory allocation and cap on the State's recovery does not comport with *Ahlborn* because "it permits DHHS to assert a lien against settlement proceeds intended (or otherwise properly allocable) to compensate the Medicaid recipient for other claims, such as pain and suffering or lost wages (i.e., in cases where one-third of the recipient's total settlement recovery is greater than

the amount DHHS expended on the recipient's behalf)."[1] (Pet. App. 42a) The court ruled that § 108A-57(a) could not be upheld as a special rule or procedure for allocating tort settlements, (Pet. App. 45a), and also found that North Carolina's statutory lien conflicted with the relevant guidance published by CMS.

The Fourth Circuit concluded that the amount of a recovery that is allocable to medical expenses must be determined pursuant to an adversarial proceeding that affords the Medicaid recipient an opportunity to rebut the statutory presumption. (Pet. App. 55a) The court therefore vacated the decision of the district court and remanded for an evidentiary hearing to determine the proper amount of DHHS's Medicaid lien.[2]

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[1] The Fourth Circuit misstates North Carolina law, which provides that the Medicaid lien is the lesser of the amount of assistance paid by DHHS on behalf of the recipient or one-third of the recovery. N.C. Gen. Stat. § 108A-57. The statutory lien would never result in a recovery of more than DHHS expended on medical services for the recipient even if one-third of the recovery exceeds the amount expended by DHHS. The Fourth Circuit did not repeat this misstatement elsewhere in its opinion, and it does not appear to have been the basis for its holding.

[2] The court rejected Respondents' argument that the district court must utilize the same "proportional analysis" that Arkansas stipulated to in *Ahlborn*, a formula which

REASONS FOR GRANTING THE PETITION

Both the North Carolina Supreme Court and the Fourth Circuit have ruled on the question of whether North Carolina's third-party recovery statute is preempted by the federal anti-lien provision as construed by this Court in *Ahlborn*. The former court held it is not preempted; the latter held it is, acknowledging the conflict.

This Court's acceptance of the case for review is necessary to resolve a direct conflict between the North Carolina Supreme Court and the Fourth Circuit, and the post-*Ahlborn* confusion regarding what "special rules and procedures for allocating tort settlements" are permitted by the Medicaid Act. This Court should make clear what *Ahlborn* suggested, but did not hold: that, in the words of CMS, "States have

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results in a proportional reduction of the medical lien when the settlement does not fully compensate for the "true value" of the case. (Pet. App. 50a) The court approvingly cited the Tenth Circuit's statement in *Price v. Wolford*, 608 F.3d 698, 707 (10th Cir. 2010), that "a reduction in a Medicaid lien can be justified only by showing a reason why the plaintiff would agree to allow the defendant to pay less than the full amount of the Medicaid lien." (Pet. App. 50a-51a)

leeway to develop a reasonable statutory scheme for apportioning medical expenses."[3]

I. THE FOURTH CIRCUIT'S DECISION DIRECTLY CONFLICTS WITH A DECISION OF THE NORTH CAROLINA SUPREME COURT.

In *Andrews*, the North Carolina Supreme Court specifically found that *Ahlborn* does not require an evidentiary hearing to determine the amount of a settlement that the parties must set aside to reimburse Medicaid. (Pet. App. 95a-96a) The court held that "the *Ahlborn* holding, limited by the parties' stipulations, did not require a specific method for determining the portion of a settlement that represents the recovery of medical expenses." (Pet. App. 93a) The court noted that *Ahlborn* had left open the possibility that special rules and procedures might be employed to meet concerns about settlement manipulation, and determined that North Carolina's procedure was a reasonable method of encouraging complete recovery for past medical payments while preventing excessive depletion of a plaintiff's recovery to satisfy the State's reimbursement lien.

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[3] The reply memo of the Centers for Medicare & Medicaid Services to the Honorable Howard Coble, Member, U.S. House of Representatives (December 23, 2009) ("Reply Memo") (Pet. App. 141a).

The Fourth Circuit reached the opposite conclusion, holding that *Ahlborn* requires that the share of a settlement designated as recovery for medical expenses be subject to adversarial testing. The Fourth Circuit ruled that § 108A-57(a) could not be upheld as a special rule or procedure for allocating tort settlements, (Pet. App. 45a), because (in its view) *Ahlborn* was actually referring to only one method of combating settlement manipulation – the use of "mini hearings." The Fourth Circuit concluded that application of North Carolina's procedure to an unallocated lump-sum settlement violated the Medicaid anti-lien provision and that the North Carolina Supreme Court's reliance on this Court's "special rules and procedures" language to uphold the statute was "misplaced." (Pet. App.45a) The Fourth Circuit also stated that North Carolina's statutory lien conflicted with the guidance published by CMS, which it described as stating, among other things, that *Ahlborn* bars States from enacting laws that permit recovery beyond what the parties have designated as payment for medical services. (Pet. App.45a-47a (discussing CMS Memorandum, Pet. App.124a-138a))

The Fourth Circuit expressly acknowledged that its decision was in direct conflict with the decision of the highest court of the State of North Carolina. (Pet. App. 5a) As such, the circumstances here present a compelling reason to accept the case for review within the scope of Rule 10(a) of the Rules of this Court.

II. CONTRARY TO THE FOURTH CIRCUIT'S HOLDING, NORTH CAROLINA'S STATUTES COMPORT WITH THE MEDICAID ACT AS CONSTRUED IN *AHLBORN*.

A. States Retain the Authority to Regulate How Tort Recoveries Must Be Allocated.

This Court's decision in *Ahlborn* was limited to the narrow issue of whether Arkansas could recover its Medicaid expenditures from the portion of a settlement that all parties, including the State, agreed represented compensation for matters separate from medical costs. *Ahlborn* did not attempt to define how to identify the portion of a recovery that represents reimbursement for medical expenses. *Ahlborn* did not preclude a State's ability to statutorily assert its priority to recover monies appropriately attributable to medical expenses as a part of the settlement process.

In *Ahlborn*, the parties — specifically including the State of Arkansas — entered into the following critical stipulations, which governed the allocation of the Medicaid recipient's settlement proceeds: (1) the value of the underlying claim (just above $3 million); (2) that the settlement amounted to only one-sixth of the value of the claim ($550,000); and (3) the specific amount representing compensation for medical expenses ($35,581.47). *Ahlborn*, 547 U.S. at 274. Arkansas nonetheless subsequently claimed that it was entitled to recover from the settlement proceeds the full amount of its medical expenditures ($215,645.30). *Id.* Thus, the narrow question presented in *Ahlborn* was

whether Arkansas was limited to recover only that portion of the settlement which the parties, prior to the entry of the settlement, had all acknowledged represented medical expenses. On that narrow question, the Court held that the exception to the anti-lien law that only allowed Arkansas to recover from the portion of the settlement that the state had agreed represented compensation for medical expenditures. *Id.* at 292. Because of the controlling stipulations, the Court had no reason to address any particular method for determining how much of a settlement, in the absence of a stipulation, represents payment for medical expenses.

The *Ahlborn* Court recognized that "some States have adopted special rules and procedures for allocating tort settlements," but ultimately "express[ed] no view on the matter" and "le[ft] unaddressed the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation." *Ahlborn*, 547 U.S. at 288 n.18. And while noting that the issue was not squarely before it, the Court acknowledged that one way to avoid manipulation of a settlement so as to "allocate away the State's interest" was to obtain "the State's advance agreement to an allocation." *Id.* at 288.

North Carolina's statutes utilize both approaches available after by *Ahlborn*: they establish criteria regarding how tort settlements are to be allocated when the Medicaid program has paid a recipient's medical expenses and they provide an advance

agreement that the State will reduce its lien if the amount of the Medicaid claim exceeds one-third of the total recovery. North Carolina law does this by requiring a recipient's attorney who has actual notice of payments made on behalf of the recipient to enforce the Medicaid program's subrogation rights. N.C. Gen. Stat. § 108A-57. Thus, before a settlement is ever reached, the recipient's attorney is aware of the precise amount that must be allocated to satisfy the Medicaid claim; the Medicaid claim is, necessarily, a part of the settlement negotiations. There is no possibility that the parties could be uncertain as to the amount that represents reimbursement for medical expenses, and therefore no reason to hold a hearing to determine the parties' intent. The parties must allocate the settlement in conformity with the statute. Furthermore, because the parties to the settlement agreement know in advance what the medical expenses portion of any settlement will be, the recipient can fully and accurately evaluate the settlement offer. The North Carolina statute "protects [Medicaid recipients'] interests while promoting efficiency in Medicaid reimbursement cases throughout North Carolina." (Pet. App. 79a-80a) As recognized by the North Carolina Supreme Court, "weighing these and other public policy considerations is the province of our General Assembly." (Pet. App. 96a)

The Fourth Circuit erred by reading into *Ahlborn* a requirement that a hearing "must determine the true value of the case" (Pet. App. 50a) and that the amount

of North Carolina's statutory lien "must be subject to adversarial testing." (Pet. App. 53a) *Ahlborn* did not hold that a post-settlement hearing must be conducted to allocate damages. In response to concerns expressed by Arkansas and the United States that private litigants might manipulate settlement allocations, the Court in *Ahlborn* observed that such a risk can be avoided either by obtaining the State's advance agreement to an allocation or, "if necessary, by submitting the matter to a court for decision." *Ahlborn*, 547 U.S. at 288. This mere suggestion of a court review does not support the Fourth Circuit's requirement for an evidentiary hearing to establish what portion of the settlement proceeds are "properly allocable to past medical expenses." (Pet. App. 51a) *Ahlborn* held nothing of the sort, and other language in the opinion leaving open the possible adoption of special rules and procedures confirms that States have other available options that are consistent with the Medicaid Act.

B. The Fourth Circuit Misread the Relevant Guidance of the Centers for Medicare & Medicaid Services.

The Fourth Circuit cited a July 3, 2006 CMS Memorandum, "State Options for Recovery Against Liability Settlements in Light of United States Supreme Court Decision in *Arkansas Department of Human Services v. Ahlborn*," Centers for Medicare & Medicaid Services ("CMS Memorandum") (Pet. App. 124a-138a), as support for its holding that North

Carolina's statute conflicts with the Medicaid Act. (Pet. App. 45a-47a) However, CMS has specifically declared that North Carolina's statute comports with the anti-lien provisions as they were construed in *Ahlborn* as well as in its post-*Ahlborn* Memorandum. That conclusion is entitled to deference.

The CMS Memorandum, after delineating the key findings of *Ahlborn*, listed actions that states may take, including (1) "enact laws which provide for a specific allocation amongst damage[s], i.e., pain and suffering, lost wages, and medical claims;" and (2) "require that cases can only be compromised with the consent of the state." (Pet. App. 129a) The North Carolina third-party recovery statute is a law "provid[ing] for a specific allocation amongst damage[s]" – it provides that up to one-third of a total recovery must be designated as payment for past medical costs. Additionally, North Carolina has put in place a law "requir[ing] that cases only be compromised with the consent of the state." North Carolina's subrogation statute provides the state's consent to compromise by automatically reducing its claim to one-third of the recovery if the recovery does not equal at least three times the amount of the Medicaid lien.

CMS maintains that North Carolina's statutes are consistent with the Medicaid Act and has specifically approved the analysis of North Carolina's procedures in the *Andrews* decision. A December 23, 2009, Reply Memo to North Carolina Congressman Howard Coble

expresses agreement with the *Andrews* decision and specifically states that neither the North Carolina statute nor the *Andrews* decision conflict with the CMS Memorandum. (Pet. App. 139a-142a)

CMS acted under the Medicaid Act's grant of authority when it issued both the CMS Memorandum and the Reply Memo. Therefore, its conclusions regarding North Carolina's law are entitled to deference. The federal Medicaid statutes comprise the prototypical "complex and highly technical regulatory program," and the Secretary of HHS has "significant expertise" in administering it. *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994). This Court has observed that "the well-reasoned views of the agencies implementing a statute 'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.'" *Bragdon v. Abbott*, 524 U.S. 624, 642 (1998) (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 139-40 (1944)). In *Ahlborn*, this Court recognized that Congress has delegated "broad regulatory authority to the Secretary [of HHS] in the Medicaid area," *Wisconsin Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 496 n.13 (2002), and that deference is therefore generally appropriate. *Ahlborn*, 547 U.S. at 292. *See also Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012) (deference accorded to CMS letters finding that state legislation complied with federal law).

Ahlborn does not empower parties to a tort settlement to allocate away a State's Medicaid lien nor

does it require that a State's appropriate share of the settlement proceeds must be judicially determined after adversarial testing. Furthermore, the Fourth Circuit relied on a misinterpretation of the guidance from CMS to support the conclusion that North Carolina's statutes are inconsistent with the Medicaid Act. Each of these reasons provide a further compelling basis for the Court to accept this case for review.

III. THE IMPORTANT ISSUES PRESENTED SHOULD BE DECIDED BY THE COURT.

In compliance with the Medicaid Act, all States have enacted some type of third-party recovery statute. Several states other than North Carolina have statutory provisions setting forth a presumptive portion of a Medicaid recipient's tort recovery as reimbursement for the provision of medical services. *See* Conn. Gen. Stat. § 17B-94(a) (Supp. 2011); Fla. Stat. Ann. § 409.910(11)(f)(1) (2009); Mich. Comp. Laws § 400.106(5) (2008); Minn. Stat. § 256.015(5) (Supp. 2011); and Ohio Rev. Code Ann. § 5101.58(G)(2) (Supp. 2011).

Furthermore, it appears that at least twenty-six other states have third-party recovery laws that do not require an "adversarial testing" of the allocation of damages of the type mandated by the decision of the

Fourth Circuit.[4] *See* Ala. Code §§ 22-6-6, 22-6-6.1 (2006); Alaska Stat. § 47.05.070 (2010); Ariz. Rev. Stat. Ann. § 36-2915 (2009); Del. Code Ann. tit. 31, § 522 (2009); Ind. Code § 12-15-8-1 through § 12-15-8-9 (2006); Iowa Code Ann. § 249A.6 (Supp. 2011); Kan. Stat. Ann. § 39-719a (2000); Ky. Rev. Stat. Ann. §§ 205.624, .626 (2006); La. Rev. Stat. Ann. § 46:446 (2010); Md. Code Ann. Health-Gen. § 15-120 (2009); Mont. Code Ann. § 53-2-612 (Supp. 2011); Neb. Rev. Stat. §§ 68-716, -916 (2009); Nev. Rev. Stat. §§ 422.293 to 422.29306 (2009); N.J. Stat. Ann. § 30:4D-7.1 (2009); N.M. Stat. §§ 27-2-23, -28(G) (2007); N.Y. Soc. Serv. Law § 104-b (Supp. 2012); Or. Rev. Stat. § 416.540 (2009); R.I. Gen. Laws § 40-6-9 (2006); S.C. Code Ann. § 43-7-440 (Supp. 2011); S.D. Codified Laws § 28-6-7.1 (2004); Tex. Hum. Res. Code Ann. § 32.033 (2001 & Supp. 2011); Utah Code Ann. § 26-19-7 (Supp. 2011); Wash. Rev. Code §§ 41.05A.060, 41.05A.070, 74.09.180, 74.09.185 (Supp. 2011); W. Va. Code § 9-5-11 (Supp. 2011); Wis. Stat. § 49.89 (2011); and Wyo. Stat. Ann. §§ 42-4-201, 42-4-202, 42-4-203 (2011).

Additionally, the Fourth Circuit's analysis has been relied upon by the Supreme Court of Appeals of West Virginia in its recent decision determining that

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[4] Some of the listed states may have administratively adopted particular review mechanisms that are not reflected in their third-party recovery statutes. However, it is not clear whether such procedures would comport with the rationale of the Fourth Circuit.

West Virginia's assignment and subrogation statute is in conflict with federal law and is therefore preempted. *See In re: E.B., a Minor*, No. 101537, 2012 W.Va. LEXIS 314 (W. Va. 21 June 2012). On the question of the appropriate method of allocating an unallocated settlement and which post-allocation funds a State's reimbursement claim may reach, the West Virginia Court ruled that the State was "limited to funds allocated solely to past medical expenses in seeking reimbursement." *Id.* at *90. The court then noted:

> It is our hope that the United States Supreme Court will clarify this issue for the benefit of the states' individual Medicaid programs. Unless and until the United States Supreme Court provides clearer guidance on this issue, this Court is persuaded by the Fourth Circuit's interpretation of *Ahlborn* provided in *Cansler*.

Id. at *95 n.35.

Only this Court's decision can resolve the conflict between the North Carolina Supreme Court and the Fourth Circuit as to the viability of North Carolina's statutory procedures, as well as the on-going uncertainty over the viability of other statutory provisions governing a State's recovery for the provision of medical services from third-party settlements involving Medicaid recipients.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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July 2012

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT
No. 10-1865

E.M.A., a minor, by and through her Guardian ad Litem, William W. Plyler; WILLIAM EARL ARMSTRONG; SANDRA ARMSTRONG,
Plaintiffs-Appellants,

v.

LANIER M. CANSLER, in his official capacity as Secretary of the North Carolina Department of Health and Human Services,
Defendant-Appellee.

Appeal from the United States District Court for the Western District of North Carolina, at Statesville. Richard L. Voorhees, District Judge. (5:07-cv-00037-RLV-DCK)

674 F.3d 290; 2012 U.S. App. LEXIS 5996

Argued: October 26, 2011
Decided: March 22, 2012

Before AGEE, DAVIS, and KEENAN, Circuit Judges.

Vacated and remanded by published opinion. Judge Davis wrote the opinion, in which Judge Keenan joined. Judge Agee wrote an opinion concurring in part, dissenting in part, and concurring in the judgment.

OPINION OF THE 4TH CIRCUIT COURT OF APPEALS, DECIDED MARCH 22, 2012

COUNSEL

ARGUED: William Bernard Bystrynski, KIRBY & HOLT, LLP, Raleigh, North Carolina, for Appellants. Belinda Anne Smith, NORTH CAROLINA DEPARTMENT OF JUSTICE, Raleigh, North Carolina, for Appellee. **ON BRIEF**: C. Mark Holt, KIRBY & HOLT, LLP, Raleigh, North Carolina; Jeffrey T. Mackie, SIGMON, CLARK, MACKIE, HUTTON, HANVEY & FERRELL, PA, Hickory, North Carolina, for Appellants. Roy Cooper, North Carolina Attorney General, Raleigh, North Carolina, for Appellee.

OPINION

DAVIS, Circuit Judge:

Under federal law, states participating in the Medicaid program are obligated (with some exceptions) to seek reimbursement from third-party tortfeasors for health care expenditures made on behalf of Medicaid beneficiaries who are tort victims. At the same time, however, states are prohibited (with some exceptions) from seeking reimbursement "from the personal property of" Medicaid beneficiaries themselves for health care expenditures made on behalf of those beneficiaries. But what if the injured Medicaid beneficiary obtains a judgment against (or enters into a settlement agreement with) the tortfeasor? Under such circumstances, what constraints are imposed as to how the state may

satisfy its mandatory claim for reimbursement? In *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), the Supreme Court provided considerable guidance in resolving this tension in the Medicaid law. The instant appeal requires us to apply the teachings of *Ahlborn* to the Medicaid program as it is administered in North Carolina.

The minor appellant, E.M.A., sustained serious injuries at birth due to the negligence of the medical professionals who attended to her delivery. As a result of E.M.A.'s injuries, the North Carolina Department of Health and Human Services ("DHHS"), through the state Medicaid program, paid more than $1.9 million in medical and health care expenses on her behalf. Meanwhile, E.M.A., through her guardian *ad litem*, and her parents, Sandra and William Earl Armstrong, individually (hereafter "Appellants"), instituted a medical malpractice action in state court. In due course, they settled the action for a lump sum of approximately $2.8 million (a sum in excess of the total Medicaid expenditures of approximately $1.9 million but well below the full value of all the tort claims). The settlement agreement did not allocate separate amounts for past medical expenses and other damages.

DHHS subsequently asserted a statutory lien on the settlement proceeds pursuant to N.C. Gen. Stat. §§ 108A-57 and - 59 (referred to herein as "the North Carolina third-party liability statutes"), which

provide that North Carolina has a subrogation right to, and may assert a lien upon, the lesser of its actual medical expenditures or one-third of the Medicaid recipient's total recovery. Thus, under the circumstances described, where DHHS's actual medical expenditures are greater than one-third of the settlement funds, the North Carolina third-party liability statutes effect an unrebuttable presumption that the state is entitled to one-third of the total settlement proceeds recovered by E.M.A. and her parents. This amount, $933,333.33 (one-third of the $2.8 million lump-sum settlement), has been paid into the registry of the state court, where the funds have remained during the pendency of this action. The parties before us do not dispute the state's entitlement to *some* reimbursement from the lump-sum settlement, but they vigorously dispute the proper allocation of the portion of the settlement proceeds held in trust by the state court.

Appellants brought this action in federal district court against Lanier M. Cansler, in his official capacity as Secretary of DHHS, seeking declaratory and injunctive relief pursuant to 42 U.S.C. § 1983. They sought to forestall payment of the amount claimed by DHHS on the basis of the provision of the federal Medicaid law known as the "anti-lien provision," 42 U.S.C. § 1396p. On cross-motions for summary judgment, the district court, relying in significant part on the reasoning of a majority opinion in a prior case by a divided Supreme Court of North Carolina which distinguished *Ahlborn* while

sustaining the state statutory regime, granted summary judgment in favor of Appellee, Secretary Cansler. Appellants filed this timely appeal

For the reasons set forth within, we disagree, respectfully, with the analysis of the Supreme Court of North Carolina, as adopted by the district court. Rather, in agreement with one of our sister circuit courts analyzing an analogous state law, we are persuaded that the unrebuttable presumption inherent in the one-third cap on the state's recovery imposed by the North Carolina third-party liability statutes is in fatal conflict with federal law. Accordingly, we vacate the judgment in favor of the Secretary and remand this action for further proceedings consistent with this opinion.

I

A

E.M.A. was born on February 25, 2000 with injuries that necessitated substantial medical treatment. As a result of the injuries she suffered at birth, E.M.A. is legally deaf and blind, and she is unable to sit, walk, crawl, or talk. Additionally, E.M.A. suffers from mental retardation and a seizure disorder. She requires between 12 and 18 hours of skilled nursing care per day. Sandra Armstrong, E.M.A.'s mother, applied for Medicaid benefits on behalf of E.M.A. on April 26, 2000. The North Carolina Medicaid program is administered by the

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Division of Medical Assistance ("DMA") of DHHS pursuant to N.C. Gen. Stat. § 108A-54 and 42 U.S.C. §§ 1396-1396v. In the application for Medicaid coverage for E.M.A., Sandra Armstrong agreed

> to give back to the State any and all money that is received by me or anyone listed on this application from any insurance company for payment of medical and/or hospital bills for which the Medical Assistance program has or will make payment. In addition, I agree that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the State to repay past or current medical expenses paid by the State. This includes insurance settlements resulting from an accident. I further agree to notify the county department of social services if I or anyone listed on this application is involved in any accident.

J.A. 82, ¶ 2.

On February 21, 2003, E.M.A. and her parents filed a lawsuit in Catawba County Superior Court alleging claims for medical malpractice. The malpractice suit sought damages on behalf of E.M.A. for her physical and developmental injuries, lost wages, pain and suffering, and future medical expenses starting at her majority. Sandra and William Earl Armstrong sought damages for past

medical expenses for E.M.A.'s care and treatment, medical expenses through E.M.A.'s eighteenth birthday, and damages for their own emotional distress.

After three years of litigation, the parties settled the medical malpractice case. Prior to consummating the settlement, Appellants were aware that DHHS had paid more than $1.9 million for the costs of E.M.A.'s medical care. Appellants contend that they gave notice of the settlement negotiations and of the mediation process to DHHS pursuant to Rule 4B of the North Carolina Rules for Mediated Settlement Conference, but no representative of DHHS ever participated in or attended the settlement discussions.[1]

On November 13, 2006, Judge Timothy Kincaid held a hearing in the Catawba County Superior Court to review the fairness and appropriateness of the settlement. Appellants allege they served DHHS with notice of the hearing, but no representative of DHHS appeared. The court approved the settlement, finding that it was fair and just, in the best interest of E.M.A., and in all respects reasonable and proper. The court likewise found the settlement to be fair in all respects as to Sandra and William Earl

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[1] It is undisputed that DHHS had a right to intervene in the malpractice action but elected not to do so.

Armstrong, and that their individual claims had been resolved by the settlement, "including, but not limited to, claims for severe emotional distress and mental anguish and liability for past, present and future medical and life care expenses." J.A. 134. Judge Kincaid noted that the plaintiffs had alleged that "[E.M.A.] suffered severe and permanent injuries and that both parents . . . have incurred liability for past, present and future medical and life care expenses for treatment of [E.M.A.]," J.A. 133, and concluded that the sums set out in the Settlement Schedule were fair and just compensation for their respective claims, J.A. 135.

Notably, neither the parties to the settlement nor the court allocated the settlement funds among the distinct claims or categories of damages. To be sure, however, Judge Kincaid recognized that DHHS had asserted a lien against the proceeds of the settlement, but for reasons not addressed by the parties before us, he apparently was not asked and/or declined to adjudicate the proper amount of the DHHS lien. Rather, he found simply that "the amount of that lien needs to be determined in light of the U.S. Supreme Court decision in [*Ahlborn*]," J.A. 136, which had been decided approximately six months earlier during the pendency of the state medical malpractice litigation. Accordingly, the court ordered that the maximum potential lien amount, as set out in the Settlement Schedule and as provided in N.C. Gen. Stat. § 108A-57(a), should be paid into an interest bearing account in the Catawba County Clerk of

Court's Office until such time as the actual amount of the DHHS lien was conclusively determined. Although the Settlement Schedule was filed under seal and is not part of the appellate record in this case, it is undisputed that the amount held in the Catawba County Clerk of Court's Office is $933,333.33, which represents one-third of the total lump-sum settlement paid to E.M.A. and her parents in resolution of the medical malpractice action.

B

On March 23, 2007, E.M.A. filed this suit in the United States District Court for the Western District of North Carolina under 42 U.S.C. § 1983 seeking declaratory and injunctive relief. She alleged a deprivation of her rights as secured by 42 U.S.C. § 1396p (the federal Medicaid anti-lien provision, discussed *infra*) and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. U.S. Const. amend. XIV, § 1, cl. 2. In her complaint, E.M.A. requested a declaratory judgment finding that: (1) DHHS does not have a lien on the proceeds paid on her behalf in settlement of the medical malpractice action or, in the alternative, determining the amount of the lien; (2) the North Carolina third-party liability statutes are unconstitutional under the federal Supremacy Clause, U.S. Const. art. VI, cl. 2, to the extent the statutes allow DHHS to assert a lien on settlement funds paid in lieu of damages for claims other than medical expenses; and (3) DHHS be enjoined from

enforcing the North Carolina third-party liability statutes in a manner that violates 42 U.S.C. §§ 1396-1396v, *Ahlborn*, and the Equal Protection Clause.[2]

The Secretary filed certain preliminary motions, which the district court granted in part and denied in part, without prejudice. E.M.A.'s parents were joined as plaintiffs by consent. Thereafter, the district court stayed the action pending final review in the North Carolina Supreme Court of *Andrews v. Haygood*, 669 S.E.2d 310 (N.C. 2008), *cert. denied sub nom. Brown v. North Carolina Department of Health and Human Services*, 129 S. Ct. 2792 (2009), a state-court appeal challenging the enforceability of the North Carolina third-party liability statutes under circumstances materially indistinguishable from the circumstances present in this case.

After the North Carolina Supreme Court sustained the North Carolina third-party liability statutes in *Andrews*, 669 S.E.2d 310, the parties filed cross-motions for summary judgment. The district court concluded that, based upon the North Carolina Supreme Court's reasoning in *Andrews* and its own independent analysis, the North Carolina third-party liability statutes are consistent with federal Medicaid law as interpreted in *Ahlborn*. Having reached this

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[2] Appellants have abandoned their equal protection claim.

conclusion of law and finding no genuine dispute of material fact remaining, the district court denied E.M.A.'s motion for summary judgment, granted the Secretary's motion for summary judgment, and dismissed E.M.A.'s case with prejudice, thereby entitling the Secretary to $933,333.33, the full amount held in trust by the state court. E.M.A., through her guardian *ad litem*, together with her parents, timely appealed. We have jurisdiction pursuant to 28 U.S.C. § 1291.

II

The outcome of the instant appeal turns upon our application of federal Medicaid law, as interpreted by the Supreme Court in *Ahlborn*, to North Carolina's statutory scheme for third-party liability, in light of the particular undisputed facts of this case involving a lump-sum personal injury settlement recovered by a minor child. We review *de novo* the district court's grant of summary judgment. *Purdham v. Fairfax Cnty. Sch. Bd.*, 637 F.3d 421, 426 (4th Cir. 2011). Similarly, "[t]he district court's analysis of the statutes in the instant case presents questions of law which we review *de novo*," *WLR Foods, Inc. v. Tyson Foods, Inc.*, 65 F.3d 1172, 1178 (4th Cir. 1995), *cert. denied*, 516 U.S. 1117 (1996), including, of course, its analysis of the Appellants' Supremacy Clause challenge. *See Sheehan v. Peveich* (*In re Peveich*), 574 F.3d 248, 252 (4th Cir. 2009).

E.M.A. and her parents argue on appeal that

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DHHS's lien against E.M.A.'s portion of the settlement proceeds violates federal Medicaid law because the lien encumbers funds that are not payment for medical expenses already incurred. Although the medical malpractice settlement was not allocated among categories of damages, E.M.A. asserts that her portion of the proceeds necessarily does not include reimbursement for medical care because a minor has no cause of action to recover past medical expenses under North Carolina common law. In the alternative, Appellants argue that "the proportional analysis undertaken in *Ahlborn* should be applied to this case," and that this court should vacate and remand for an evidentiary hearing to determine the proper amount of the state's lien. Br. of Appellants at 25.

The Secretary responds, citing to the North Carolina Supreme Court's majority opinion in *Andrews*, that the district court correctly held that the North Carolina third-party liability statutes, N.C. Gen. Stat. §§ 108A-57 and -59, are consistent with federal Medicaid law as construed in *Ahlborn*. The Secretary further asserts that, having made this determination, the district court was not required to rule on the applicability of North Carolina common law to the federal and state statutes because the statutes abrogate the common law. Finally, the Secretary argues that *Ahlborn* does not support E.M.A.'s alternative theory of proportional analysis for reducing the state's Medicaid lien.

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For the reasons set forth herein, although we agree that common law principles play no role in the circumstances presented in this case, we are persuaded that Appellants have the better of the argument with respect to federal law as explicated in *Ahlborn*. E.M.A.'s argument that DHHS cannot assert a lien against her portion of the settlement funds because a minor cannot recover for past medical expenses under North Carolina common law fails because the state statutes at issue clearly abrogate the common law. Nevertheless, we shall vacate the judgment because the North Carolina third-party liability statutes, N.C. Gen. Stat. §§ 108A-57 and -59, as applied in this case, fail to comply with federal Medicaid law as interpreted by the Supreme Court in *Ahlborn*. As the unanimous *Ahlborn* Court's decision makes clear, *federal Medicaid law limits North Carolina's recovery to settlement proceeds representing payment for medical expenses*. In the event of a lump-sum settlement, as in this case, the sum certain allocable to medical expenses must be determined, in the absence of a stipulation by the affected parties, by judicial determination or some similar adversarial process, before the state may recoup its Medicaid outlays. *Accord Tristani ex rel. Karnes v. Richman*, 652 F.3d 360, 377-78 (3d Cir. 2011) (interpreting Pennsylvania law).

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III

A

We begin with a summary of the relevant provisions of federal law. The Medicaid program, launched in 1965 with the enactment of Title XIX of the Social Security Act, as added, 79 Stat. 343, 42 U.S.C. §§ 1396-1396v, is a cooperative program by which the federal government pays a percentage of the costs a state incurs for medical care for individuals who cannot afford to pay their own medical costs. *Ahlborn*, 547 U.S. at 275. Although states are not required to provide Medicaid assistance, all 50 states currently do. *Id.* In exchange for receiving federal financial support for state-run Medicaid programs, states must comply with federal Medicaid laws, including statutory third-party liability requirements, 42 U.S.C. §§ 1396a(a)(25)(A), (B), (H); 1396k, and anti-lien provisions, *id.* §§ 1396a(a)(18), 1396p. In order to comply with requirements in federal Medicaid law, North Carolina has enacted its own third-party liability statutes, comprised of an assignment statute, N.C. Gen. Stat. § 108A-59, and a subrogation statute, N.C. Gen. Stat. § 108A-57. *See infra* pp. 13-14.

States providing Medicaid assistance must comply with several provisions concerning third-party liability. For instance, states are required to "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available

under the [State's Medicaid] plan." 42 U.S.C. § 1396a(a)(25)(A). In addition to this identification requirement, the state agency administering the Medicaid program (here DHHS) must seek reimbursement for medical assistance to the extent of such legal liability. *Id.* § 1396a(a)(25)(B). In order to secure its reimbursement from liable third parties, the state must,

> to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, [have] in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.

Id. § 1396a(a)(25)(H). Consistent with this provision, as a condition to receiving state medical assistance, individuals are required

> to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this title [42 USCS §§ 1396 et seq.] and on whose behalf the individual has the legal authority to execute an assignment of such rights, to

> support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party.

Id. § 1396k(a)(1)(A). Federal Medicaid law further provides that "any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of" the Medicaid recipient. *Id.* § 1396k(b). Any funds remaining after the state and federal Medicaid programs are reimbursed are then paid to the recipient. *Id.*

Although participating states are required under federal Medicaid law to seek recovery from liable third parties, as set forth above, "the federal statute places express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf." *Ahlborn*, 547 U.S. at 283. These limitations are contained in 42 U.S.C. §§ 1396a(a)(18) and 1396p. Section 1396a(a)(18) provides that a state plan for medical assistance must comply with § 1396p, which in turn prohibits states from imposing liens against, or seeking recovery of benefits paid from, a Medicaid recipient. Subsection 1396p(a) prohibits imposition of a lien "against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." Subsection 1396p(b) further provides that "no adjustment or recovery of any medical assistance

correctly paid on behalf of an individual under the State plan may be made."[3]

The Supreme Court has characterized the third-party liability provisions in federal Medicaid law as an exception to the anti-lien provisions, stating that "[t]o the extent that the forced assignment [of payments that constitute reimbursement for medical expenses] is expressly authorized in §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision." *Ahlborn*, 547 U.S. at 284 (citing *Wash. State Dep't of Soc. & Health Servs. v. Guardianship Estate of Keffeler*, 537 U.S. 371, 383-85, & n.7 (2003)). At the same time, the Supreme Court has emphasized that this exception is strictly limited – a state cannot force assignment of, or place a lien on, any property that does not constitute reimbursement for medical expenses. *Id.* at 284-85 ("[T]he exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.").

B

Next, we outline the state law provisions that are relevant to this case. As noted above, North Carolina participates in the federal Medicaid program, and DHHS is the North Carolina regulatory body charged

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[3] While there are a few exceptions to the prohibitions in 42 U.S.C. §§ 1396p(a) and (b), these exceptions are not relevant to this case.

with establishing and administering the Medicaid program throughout the state in accordance with Title XIX of the federal Social Security Act, 42 U.S.C. §§ 1396-1396v. N.C. Gen. Stat. § 108A-54. In order to comply with the federal third-party liability requirements discussed *supra*, North Carolina has enacted an assignment statute, *id* § 108A-59, and a subrogation statute, *id.* § 108A-57. Section 108A-59(a) provides that, "[n]othwithstanding any other provisions of the law, by accepting medical assistance, the recipient shall be deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise to which [the recipient] may be entitled." Implementation of the recipient's statutory assignment is governed by § 108A-57(a), the subrogation statute, which provides:

> Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance, or of the beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person . . . Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the

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> Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but the amount paid to the Department shall not exceed one-third of the gross amount to be retained or recovered.

Accordingly, under the state's third-party liability statutes, North Carolina has a subrogation right to, and may assert a lien upon, the lesser of its actual medical expenditures or one-third of the Medicaid recipient's total recovery.[4] *See id.*

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[4] As the Third Circuit has pointed out, *see Tristani ex rel. Karnes v. Richman*, 652 F.3d 360, 368 n.10 (3d Cir. 2011), *Ahlborn* does not flatly hold that statutory liens such as those created by North Carolina law are permissible. Rather, *Ahlborn* assumed, without deciding, the propriety of such laws. *See id.* ("To date, no federal appellate court has ruled on the validity of Medicaid liens limited to medical costs. Numerous district courts and state appellate courts, however, have assumed that such liens are valid in the wake of *Ahlborn* . . . . Although these decisions have permitted the use of Medicaid liens limited to medical costs, the majority of them have not clearly articulated their rationale for doing so. Indeed, some courts appear to be under the misapprehension that the Supreme Court held such liens to be

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With commendable candor, the Secretary concedes that the statutory presumption that the state's recovery of one-third of an unallocated lump-sum tort settlement is fair and appropriate rests on nothing more than the state's notion of "how attorneys and insurance adjusters typically value tort cases." *See* Br. of Appellee at 16 (citing and quoting Dorsey D. Ellis, Jr., *Fairness and Efficiency in the Law of Punitive Damages*, 56 Cal. L. Rev. 1, 58 n.248 (1982) ("[T]hree times the special damages is often used as a rule of thumb for settling personal injury claims. *See* H. Ross, *Settled Out of Court* 108 (1970).")). The question posed by this appeal is whether the state's mere interest in "efficiency" is sufficient to satisfy the federal anti-lien provision. We hold that it is not.

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permissible in *Ahlborn*."); *see also id.* at 379 n.1 (Pollak, D.J., sitting by designation, dissenting) ("As the majority recognizes, the Supreme Court's decision in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 280 n.9 (2006), assumed without deciding that 'a State can . . . requir[e] an "assignment" of part of, or plac[e] a lien on, the settlement that a Medicaid recipient procures on her own."). Appellants have not asserted that the North Carolina lien statute is wholly unenforceable. They limit their challenge to the unrebuttable presumption arising from the statutory one-third provision.

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C

(1)

The interplay among the above-described federal and state legal principles creates a measure of tension. In *Ahlborn*, the Supreme Court reconciled seemingly conflicting legal standards when it considered whether an Arkansas third-party liability statute permitting the state to claim a right to the *entirety* of the costs it paid on a Medicaid recipient's behalf, regardless of whether that amount exceeded the portion of the recipient's judgment or settlement representing past medical expenses, violated federal Medicaid law. 547 U.S. at 278. In an opinion by Justice Stevens for a unanimous Court, *Ahlborn* held that Arkansas' assertion of a lien on a Medicaid recipient's tort settlement in an amount exceeding the stipulated medical-expenses portion was not authorized by federal Medicaid law; to the contrary, the state's attempt to do so was affirmatively prohibited by the general anti-lien provision in 42 U.S.C. § 1396p. *Id.* at 292.

For the purposes of our analysis in the instant appeal, the facts of *Ahlborn* are highly instructive. Following Heidi Ahlborn's car accident with allegedly negligent third parties, the Arkansas Department of Health and Human Services ("ADHHS")[5] determined

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[5] While the State's petition for certiorari in *Ahlborn* was pending in the Supreme Court, the

that she was eligible for Medicaid and paid providers $215,645.30 on her behalf. *Id.* at 273. She filed a state-court suit against the alleged tortfeasors seeking damages for past medical costs and for other items, including pain and suffering, loss of earnings and working time, and permanent impairment of her future earning ability. *Id.* ADHHS intervened in *Ahlborn's* lawsuit to assert a lien on the proceeds of any third-party recovery she might obtain. *Id.* at 274. The case was settled for a lump sum of $550,000, which was not allocated between her various claims. *Id.* ADHHS did not participate or ask to participate in the settlement negotiations, and did not seek to reopen the judgment after the case was dismissed, but did assert a lien against the settlement proceeds for the full amount it had paid for Ahlborn's care. *Id.*

Ahlborn filed a declaratory judgment action in federal district court seeking a declaration that the state's lien violated federal law insofar as its satisfaction would require depletion of compensation for her injuries other than past medical expenses. *See Ahlborn v. Ark. Dep't of Human Servs.*, 280 F. Supp. 2d 881 (E.D. Ark. 2003). Notably, the parties stipulated that the settlement amounted to approximately one-sixth of the reasonable value of

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Arkansas Department of Human Services changed its name to "Department of Health and Human Services." Since the Supreme Court's decision, the agency has reverted to its original name.

Ahlborn's claim and that, if her construction of federal law was correct, ADHHS would be entitled to only the prorated portion of the settlement that constituted reimbursement for medical payments made ($35,581.47, or one-sixth of $215,645.30, the full amount paid by ADHHS for her medical expenses related to the car accident). *Id.* at 883.

Ruling on cross-motions for summary judgment, the district court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned to ADHHS her right to any recovery from the third-party tortfeasors to the full extent of Medicaid's payments for her benefit. *Id.* at 888. Accordingly, ADHHS was entitled to a lien in the full amount of $215,645.30. The Eighth Circuit reversed, holding that ADHHS was entitled only to that portion of the settlement that represented payments for medical care. *Ahlborn v. Ark. Dep't of Human Servs.*, 397 F.3d 620, 628 (8th Cir. 2005). ADHHS sought further review in the Supreme Court, which granted *certiorari* and affirmed the Eighth Circuit. *Ahlborn*, 547 U.S. at 292.

The Supreme Court held that Arkansas' third-party liability lien attached only to the portion of Ahlborn's settlement that was designated by stipulation for past medical expenses paid by Medicaid, or $35,581.47. *Id.* The Court found that the remainder of ADHHS 's claim could not be asserted against the balance of the settlement proceeds. *Id.* at 280-81. The Court reasoned that the anti-lien

provisions in the federal Medicaid statutes, 42 U.S.C. §§ 1396a(18) and 1396p, must be interpreted in view of 42 U.S.C. §§ 1396a(a)(25) and 1396k(a), which provide that states shall require individuals, as a condition to receiving state medical assistance, to assign the state any rights the individual may have "to payment for medical care from any third party," 42 U.S.C. § 1396k(a)(1)(A). *Id.* at 283-84. The Court explained that

> there is no question that the State can require an assignment of the right, or a chose in action, to receive payments for medical care . . . The State can also demand . . . that the recipient "assign" in advance any payments that may constitute reim-bursement for medical costs . . . As long as the assignment rights are authorized under 42 U.S.C. §§ 1396a(a)(25) and 1396k(a), such assignments are considered exceptions to the anti-lien provision.

Id. at 284. The Court concluded that the federal third-party liability provisions require an assignment of no more than the right to recover the portion of the settlement proceeds which are designated for past medical bills paid by Medicaid, *id.* at 282, and that the federal anti-lien provision prohibits state Medicaid programs from asserting a third-party liability claim against a Medicaid beneficiary's settlement or judgment for personal injury damages other than medical expenses, *id.* at 286.

(2)

In *Andrews*, 669 S.E.2d 310, upon which the district court below heavily relied, the North Carolina Supreme Court rejected, by a 4-3 vote, a Supremacy Clause challenge to N.C. Gen. Stat. §§ 108A-57 and -59, concluding over a vigorous dissent that the North Carolina third-party liability statutes did not run afoul of the Supreme Court's interpretation of federal Medicaid law in *Ahlborn*. We believe it useful to review in some detail the course of legal developments in the state courts.

In *Ezell v. Grace Hospital, Inc.*, 623 S.E.2d 79 (N.C. Ct. App. 2005), a pre-*Ahlborn* case, the North Carolina Court of Appeals held that § 108A-57(a) requires reimbursement only to the extent of the third party's legal liability for injuries resulting in medical care paid by Medicaid, effectively vitiating the impact of the one-third-of-settlement provision. 623 S.E.2d at 83. Judge Steelman concurred in part and dissented in part, reasoning that "[DHHS's] right of subrogation under N.C. Gen. Stat. § 108A-57(a) is broad rather than narrow," and finding that the state was entitled to full satisfaction of its lien under North Carolina law. *Id.* at 63-64 (Steelman, J., concurring in part and dissenting in part) (concluding that DHHS was subrogated to the entire amount of the settlement, subject only to the one-third limitation found in § 108A-57(a), irrespective of whether some of the settlement amount was intended to account for

pain and suffering and not medical damages).

Judge Steelman's dissent provided an automatic appeal to the North Carolina Supreme Court under N.C. R. App. P. 14(b)(1), and eventually served as the basis for a summary reversal when, on appeal, the North Carolina Supreme Court reversed the Court of Appeals and adopted Judge Steelman's dissent by per curiam opinion. *Ezell v. Grace Hosp., Inc.*, 631 S.E.2d 131 (N.C. 2006), *rev'g per curiam for reasons stated in the dissenting opinion*, 623 S.E.2d 79 (N.C. Ct. App. 2005). Curiously, although the North Carolina Supreme Court decided Ezell on June 30, 2006, it made no mention of *Ahlborn*, which the United States Supreme Court had decided two months earlier on May 1, 2006. Moreover, on December 14, 2006, the North Carolina Supreme Court summarily denied a petition for rehearing in *Ezell* pursuant to N.C. R. App. P. 31, which set out arguments based on *Ahlborn*. *Ezell v. Grace Hosp., Inc.*, 641 S.E.2d 4 (N.C. 2006).

Then, not long afterwards, in *Andrews v. Haygood*, 655 S.E.2d 440 (N.C. Ct. App. 2008), the North Carolina Court of Appeals once again considered whether, in an action to determine the proper amount of a Medicaid lien on a medical malpractice settlement, the trial court erred in concluding that the North Carolina Supreme Court's decision in *Ezell* was controlling, and the United States Supreme Court's decision in *Ahlborn* was not. *Andrews*, 655 S.E.2d at 441-42. The intermediate

appellate court concluded that *Ezell* was binding, *id.* at 442, and that since the North Carolina Supreme Court decided *Ezell* after *Ahlborn* was decided, and subsequently denied the petition for rehearing, the North Carolina Supreme Court had understood *Ahlborn* to have no effect on North Carolina's third-party liability statutes, *id.* at 443. The North Carolina Court of Appeals reasoned that, "[although we recognize that the Arkansas statute discussed in *Ahlborn* is similar to [N.C. Gen. Stat. § 108A-57(a)], it is well settled that the construction of the statutes of a state by its highest courts is to be regarded as determining their meaning." *Id.* (internal citations and quotation marks omitted).

Judge Wynn, then a member of the North Carolina Court of Appeals, disagreed with the majority in *Andrews*, concluding that the North Carolina Supreme Court had not yet squarely answered the question presented in the case, and therefore "certif[ied] by dissent for a decision on the issue of whether the amount of State Division of Medical Assistance's subrogation on a Medicaid recipient's settlement is controlled by the United States Supreme Court's decision in [*Ahlborn*]." *Id.* at 444 (Wynn, J., dissenting). Judge Wynn noted that the state supreme court's reversal of the North Carolina Court of Appeals' decision in *Ezell* was explained only as "for the reasons stated in the dissenting opinion," that the dissenting opinion adopted by the supreme court had neither considered nor mentioned *Ahlborn*, and that the Supreme Court

denied the motion for rehearing in *Ezell* with one word: "Denied." *Id.* (internal citations and quotation marks omitted).

Judge Wynn's dissent further emphasized that "the North Carolina statute at issue in [*Andrews*] is materially indistinguishable from the Arkansas statutory provisions found by a unanimous United States Supreme Court in *Ahlborn* to be pre-empted by federal law." *Id.* Judge Wynn reasoned,

> The principal difference between the North Carolina and Arkansas statutes is that the latter provides no ceiling or limit on the amount of recovery allowed to the ADHS; rather, the statute explicitly stated that ADHS was entitled to recover the full amount of the benefits paid to the recipient . . . . North Carolina, by contrast, allows DMA to take at most one-third of the gross amount of the settlement, regardless of whether that fully satisfies the amount paid in medical benefits . . . . Nevertheless, the basic thrust of the statutes is the same: under both, the State has an automatic lien on the full amount of any settlement with a third party reached by a Medicaid settlement, regardless of what expenses or damages those funds are designated to compensate.

Id. at 445. Accordingly, Judge Wynn concluded that "the Arkansas statute – and likewise, our North

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Carolina statute – conflicts with federal Medicaid statutes by allowing the State to recover from a recipient settlement funds that were for purposes other than medical expenses." *Id.* He explained that because the settlement at issue in *Andrews*, unlike the settlement in *Ahlborn*, was not allocated as to particular claims, "the holding of *Ahlborn* dictates that the trial court must hold an evidentiary hearing as to what portion of the settlement is designated for medical expenses prior to determination of the amount of repayment to be made to DMA." *Id.* at 446.

Upon further appellate review, the North Carolina Supreme Court considered "whether the statutory framework governing the State's subrogation claim for medical expenses on a Medicaid recipient's tort claim settlement complies with federal Medicaid law as interpreted by the Supreme Court of the United States in [*Ahlborn*]." *Andrews*, 669 S.E.2d at 311. The appellant trustee of the settlement account argued that, absent an agreement between the parties, federal law requires a judicial determination of the portion of a tort claim settlement that represents the recovery of medical expenses. *Id.* at 312. In response, the state contended that the statutory one-third limiting provision complies with *Ahlborn*'s interpretation of federal Medicaid law, and that judicial apportionment of medical expenses from the settlement was therefore not required. *Id.* The North Carolina Supreme Court agreed with the state and affirmed the Court of Appeals, stating that "[b]ecause *Ahlborn* does not

mandate a specific method for determining the medical expense portion of a plaintiff's settlement, we uphold North Carolina's reasonable statutory scheme." *Id.* at 311.

Thus, when it finally confronted the issue of *Ahlborn's* effect on the North Carolina third-party liability statutes, the North Carolina Supreme Court read *Ahlborn* narrowly and concluded that it "controls [only] when there has been a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement. In those cases, the State may not receive reimbursement in excess of the portion so designated." *Id.* at 313. The court further emphasized that "the *Ahlborn* holding, limited by the parties' stipulations, did not require a specific method for determining the portion of a settlement that represents the recovery of medical expenses." *Id.* Noting that *Ahlborn* recognized that some states have adopted "special rules and procedures" for allocating tort settlements under such circumstances, but ultimately expressed no view on the matter, the *Andrews* court determined that "*Ahlborn* thus does not mandate a judicial determination of the portion of a settlement from which the State may be reimbursed for past medical expenses. Instead, the Supreme Court left to the States the decision on the measures to employ in the operation of their Medicaid programs." *Id.* (citing *Ahlborn*, 575 U.S. at 288 n.18) (internal quotation marks omitted).

Applying this interpretation of *Ahlborn*, the

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North Carolina Supreme Court majority found that "the one-third limitation of section 108A-57(a) thus comports with *Ahlborn* by providing a reasonable method for determining the State's medical reimbursements, which it is required to seek in accordance with federal Medicaid law." *Id.* at 314 (citing 42 U.S.C. § 1396a(a)(25)(A)-(B)). The United States Supreme Court subsequently denied the plaintiff's petition for *certiorari*. *See* Brown, 129 S. Ct. 2792.

In her dissenting opinion in *Andrews*, Justice Hudson agreed with the majority that *Ahlborn* does not mandate a specific method for determining the medical expense portion of a plaintiff's settlement, but emphasized that the *Ahlborn* Court nevertheless did explicitly hold that a state may not violate the anti-lien provisions of 42 U.S.C. §§ 1396a(a)(18) and 1396p by requiring a Medicaid recipient to reimburse it out of settlement funds designated for (or otherwise properly allocable to) purposes other than medical care. *Id.* at 314 (Hudson, J., dissenting, joined by JJ. Brady and Timmons-Goodson) (internal citations and quotation marks omitted). Justice Hudson ultimately concluded, however, that "the terms of the set-tlement [in *Andrews*] provide[d] insufficient detail to allow [the *Andrews* court] to determine whether the application of N.C. Gen. Stat. § 108A-57(a) would violate the anti-lien pro-visions of the federal Medicaid statutes, pursuant to the holding in *Ahlborn*." *Id.*; *See also id.* at 317 ("[A]pplication of the bright-line rule articulated by the majority in a case

like this one, in which there has been no allocation, could allow precisely the result that is explicitly barred by *Ahlborn*.").

(3)

In the instant case, the district court recognized that *Andrews* was not binding upon it, but adopted the North Carolina Supreme Court's legal analysis and holding that the state's third-party liability statutes comport with federal Medicaid law and *Ahlhorn*. *Armstrong v. Cansler*, 722 F. Supp. 2d 653, 655-58 (W.D.N.C. 2010). The district court agreed with the *Andrews* court's determination that the Supreme Court's holding in *Ahlborn* was "limited to a proscription against the State receiving reimbursement in excess of the portion *expressly stipulated* as recovery for medical expenses in a Medicaid recipient's settlement with a third party." *Id.* at 656 (emphasis added). The district court further agreed with the *Andrews* court's "infer[ence] that a State may adopt a statutory method for [determining the portion of a settlement that represents payment for medical expenses] in the absence of prior judicial allocation," such as the one-third limitation in N.C. Gen. Stat. § 108A-57(a). *Id.*

The district court then undertook its own independent analysis of the North Carolina third-party liability statutes, and thereby confirmed its conclusion that there is no conflict between the state's third-party liability scheme and federal law.

Id. at 656-58. The district court determined that North Carolina has complied with the federal requirements that it "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the [Medicaid] plan" and "seek reimbursement for assistance to the extent of such legal liability" by enacting the State Plan for Medical Assistance, which includes an assignment statute, N.C. Gen. Stat. § 108A-59, and a subrogation statute, N.C. Gen. Stat. § 108A-57. *Id.* at 657 (quoting 42 U.S.C. § 1396a(a)(25)(A)-(B)). The district court further reasoned that, by preventing the state from recovering more than one-third of a Medicaid recipient's settlement in the absence of judicial allocation, regardless of whether the state in fact provided more assistance, the North Carolina statutory scheme avoids the conflict at issue in *Ahlborn*. *Id.* (finding that the lesser of the state's past medical expenditure or one-third of the recipient's total recovery "essentially defines" the portion of the settlement that represents payment for medical expenses in cases involving a lump-sum settlement) (internal citation and quotation marks omitted). Unlike the Arkansas statute at issue in *Ahlborn*, the district court noted, the North Carolina statute provides a reasonable means of calculating the portion of the settlement agreement representing medical expenses, and then forbids the state from imposing a lien on the remainder of the settlement. *Id.* Finally, the district court noted that an intermediate appellate court in Florida had recently upheld Florida's nearly identical statutory scheme,

which imposes a fifty-percent cap on the portion of a Medicaid recipient's award from a third-party tortfeasor that is recoverable by the state where the parties have not allocated medical costs, on the basis that the state's stipulation concerning the portion of the settlement proceeds attributable to medical expenses was central to the Supreme Court's reasoning in *Ahlborn*. *Id.* at 658 (citing *Russell v. Agency for Health Care Admin.*, 23 So. 3d 1266 (Fla. 2d Dist. Ct. App. 2010)).

IV

A

E.M.A.'s primary argument on appeal is that DHHS's lien on her settlement proceeds violates the federal anti-lien statute, 42 U.S.C. § 1396p, because she did not recover for past medical expenses.[6] E.M.A.

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[6] In connection with their contention that under North Carolina law a minor lacks a cause of action for the costs of medical care, Appellants contend that the Superior Court allocated the settlement proceeds between E.M.A. and her parents, with E.M.A. receiving 88 percent of the total and her parents receiving the remaining 12 percent. Consequently, they contend, the amount of North Carolina's recoverable reimbursement is capped at one-third of the 12 percent of the lump-sum settlement awarded to Sandra and William Earl Armstrong.

contends that although her lump-sum settlement was not allocated between various claims (either by stipulation or judicial determination), her recovery necessarily does not include reimbursement for past medical expenses because a minor has no cause of action for past medical expenses under North Carolina common law. *See Vaughan v. Moore*, 316 S.E.2d 518, 520 (1988). Notably, although E.M.A. asserted this argument in her motion for summary judgment, the district court made no mention of this issue in its opinion. The Secretary contends that "[t]he relevant federal and state statutes applicable to Medicaid recipients abrogate the common law and establish the basis for DHHS to recover a portion of the funds paid for medical services provided to the minor child." Br. of Appellee at 8.

Neither the federal law nor the state law at issue

The alleged apportionment of 12 percent to Sandra and William Earl Armstrong is not evident from the court's order, however, and the Secretary takes issue with Appellants' characterization. *See* Br. of Appellee at 7 (stating that "[appellants'] assertion contradicts the plain language of the order which provides that the funds be paid either to Medicaid or to the minor plaintiff's special needs trust. The record does not support [appellant]s' new apportionment theory."). In the view we take of the case, we need not further explore this aspect of the parties' contentions.

in this case mentions the Medicaid beneficiary's age or minority status in setting forth third-party liability and assignment requirements. Indeed, the North Carolina assignment statute provides that "*[n]othwithstanding any other provisions of the law*, by accepting medical assistance, *the recipient* shall be deemed to have made an assignment to the State of the right to third party benefits, . . . to which he may be entitled." N.C. Gen. Stat. § 108A-59(a) (emphases added). Similarly, the North Carolina subrogation statute provides that "*[n]otwithstanding any other provisions of the law*, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, shall be subrogated to all rights of recovery, contractual or otherwise, of *the beneficiary* of this assistance . . ." N.C. Gen. Stat. § 108A-57(a) (emphases added). Thus, with respect to E.M.A., who is both a "recipient" and "beneficiary" of medical assistance, the North Carolina third party liability statutes, N.C. Gen. Stat. §§ 108A-57(a), 59(a), by their plain language abrogate the common law rule that a minor cannot recover for medical expenses. *See Campbell v. N.C. Dep't of Human Resources*, 569 S.E.2d 670, 672 (N.C. Ct. App. 2002) (finding that a minor is a "recipient" of medical assistance under N.C. Gen. Stat. § 108A-25(5), which defines "recipient" as "a person to whom, or on whose behalf, assistance is granted under this Article," and a "beneficiary" of medical assistance under N.C. Gen. Stat. § 108A-57, pursuant to the plain and definite meaning of the term as commonly used); *see also id.* ("[P]laintiff cites no authority, and we find none, to

support his contention that a beneficiary in the meaning of § 108A-57, or a recipient in the meaning of § 108A-59, must be one who receives a direct cash payment or relief from debt, or who has the legal right to bring suit for medical benefits.").

The North Carolina Court of Appeals considered a distinct but analogous argument in *Ezell*, 623 S.E.2d 79, in which one of the issues before the court on appeal was whether the trial court committed reversible error in its application of common law principles of equity to the state's right of subrogation under N.C. Gen. Stat. § 108A-57(a). 623 S.E.2d at 81. The court held that § 108A-57(a) abrogates the equitable principles of common law. *Id.* at 81-82. The court reasoned that

> [i]n matters of statutory construction, this Court must ascertain and effectuate the intent of the legislative body. It is well-established that legislative intent may be determined from the language of the statute, and if a statute is facially clear and unambiguous, leaving no room for interpretation, the courts will enforce the statute as written. We conclude that the plain language of the statute here precludes the application of equitable subrogation principles. We conclude that the legislature specifically abrogated the application of

> common law principles of equity when it stated that the State "shall be subrogated to all rights of recovery," "notwithstanding any other provisions of the law." . . . [W]e must enforce the statute as written and if the legislature wishes for common law equitable principles to apply to this statute, it may certainly amend it accordingly.

Id. (internal citations and quotation marks omitted). The *Ezell* court's reasoning applies with equal force here.[7] Like the *Ezell* court, we find that the plain language of the North Carolina assignment and subrogation statutes quoted above demonstrates the North Carolina legislature's intent "to specifically abrogate[ ] the application of [certain] common law principles,"*see Ezell*, 623 S.E.2d at 81-82, including, as relevant here, the common law rule that a minor

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[7] The Secretary argues in the alternative that, even if § 108A-57(a) does not abrogate the common law in this case, DHHS has a right to subrogation of E.M.A.'s settlement proceeds because the common law doctrine of necessaries provides that an infant may be liable for necessary medical expenses even though she is living with a parent who has the duty to provide the same when the parent does not so provide. The Secretary argues that this common law doctrine, and not the rule E.M.A. urges, applies in this case. We need not address this argument, however, for as we conclude, the statute does abrogate the common law.

has no claim for past medical expenses insofar as it conflicts with the state's rights of recovery against a third party tortfeasor.[8] *See, e.g., Christenbury v. Hedrick*, 234 S.E.2d 3, 5 (N.C. App. 1977) ("It is well settled that the common law of England is in force in this State to the extent that it is not destructive of repugnant to, or inconsistent with our form of government, and to the extent that it has not been abrogated or repealed by statute or has not become obsolete; however, when the General Assembly legislates in respect to the subject matter of any common law rule, the statute supplants the common law and becomes the public policy of this State in respect to that particular matter.") (citation omitted). Accordingly, we hold that, in light of the comprehensive statutory scheme before us, E.M.A.'s share of the settlement proceeds at issue in this case is not shielded from the state's reimbursement claim

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[8] We further note that in *Ezell* and *Andrews*, North Carolina's appellate courts allowed the state to recover its Medicaid outlays for medical care costs of a tort victim minor suing for birth injuries in a medical malpractice tort action, These post-*Ahlborn* cases cannot be rationally explained unless the North Carolina courts have determined, implicitly if not explicitly, that the third-party liability statutes abrogate the common law.

by virtue of her minority.[9]

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[9] In a post-*Ahlborn* case presenting an analogous issue, the Supreme Court of Pennsylvania considered whether, under Pennsylvania's Fraud and Abuse Control Act (which addresses a variety of matters relating to the Medicaid program, including third-party liability), the Pennsylvania Department of Public Welfare could obtain reimbursement for Medicaid expenditures on behalf of a disabled minor where a claim for medical expenses rests with the minor's parents under Pennsylvania common law and the parents' claim was barred by the statute of limitations. *E.D.B. ex D.B. v. Clair*, 987 A.2d 681, 682-83 (Pa. 2009); *see id.* at 691 (holding that, "pursuant to the Fraud and Abuse Control Act, a Medicaid beneficiary has a cause of action against his or her tortfeasor to recover and reimburse DPW for Medicaid benefits received during the beneficiary's minority"). We agree with the *E.D.B.* court that

> Common law jurisprudence fails to speak to the central issue in this case. The policy questions that are implicated focus not on parental duty but on protection of the public fisc in the provision of medical assistance to minors whose parents do not have the financial means to do so. The common law is silent as to the provision of medical care to needy minors and does not contemplate state involvement in administering such care. Accordingly, our resolution of the instant case is based on interpretation of the

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(1)

Given that North Carolina common law does not bar DHHS's lien against E.M.A.'s settlement proceeds, we are faced with the same question considered by the North Carolina Supreme Court in *Andrews*: Whether North Carolina's third-party liability statutes comport with federal Medicaid law and *Ahlborn* merely because the subrogation statute, N.C. Gen. Stat. § 108A-57, "caps" the state's recovery at the lesser of the actual medical expenses paid or one-third of the total settlement. The North Carolina Supreme Court in *Andrews* and the district court in this case adopted a narrow interpretation of *Ahlborn*, limiting its holding to cases in which the parties have stipulated to or otherwise allocated settlement proceeds between different categories of damages, thereby identifying a sum certain for medical expenses. Thus, these decisions are based on the view that *Ahlborn* is inapplicable in cases involving an unallocated lump-sum settlement, such as the instant matter.

On the contrary, however, nothing in Justice

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relevant statutory law, which incorporates social welfare developments independent of common law jurisprudence.

Id. at 691 n.10.

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Stevens's opinion for a unanimous court in *Ahlborn* supports such a crabbed application of that case. The *Ahlborn* Court addressed the specific issue of "whether [ADHHS] can lay claim to more than the portion of [the recipient's] settlement that represents medical expenses." 547 U.S. at 280. The Court in no way rested its analysis of this issue on whether there has been a prior determination or stipulation as to the medical expenses portion of a Medicaid recipient's settlement. Thus, *Ahlborn* is properly understood to prohibit recovery by the state of more than the amount of settlement proceeds representing payment for medical care already received. The North Carolina statute's one-third cap on the state's recovery against a Medicaid recipient's settlement proceeds does not satisfy *Ahlborn* insofar as it permits DHHS to assert a lien against settlement proceeds intended (or otherwise properly allocable) to compensate the Medicaid recipient for other claims, such as pain and suffering or lost wages (i.e., in cases where one-third of the recipient's total settlement recovery is greater than the amount DHHS expended on the recipient's behalf).[10] *See Andrews*, 669 S.E.2d at 607-09 (Hudson,

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[10] We observe that the consent language included in the application for benefits executed by Sandra Armstrong would appear to reflect exactly this understanding. Sandra Armstrong agreed

> to give back to the State any and all money that is received by me or anyone listed on this application from my insurance company *for*

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payment of medical and/or hospital bills for which the Medical Assistance program has or will make payment. In addition, I agree that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the State to repay past or current medical expenses paid by the State. This includes insurance settlements resulting from an accident. I further agree to notify the county department of social services

J., dissenting) (concluding that the North Carolina statutes conflict with federal Medicaid law by allowing the state to recover from a recipient funds that were for purposes other than medical expenses); *Andrews*, 655 S.E.2d at 445 (Wynn, J., dissenting) (same).

(2)

In determining that N.C. Gen. Stat. § 108A-57(a) complies with *Ahlborn* by imposing what it regarded as a "reasonable cap" on the state's lien where recovery for past medical expenses is not expressly allocated, the North Carolina Supreme Court in *Andrews* relied primarily on a footnote in *Ahlborn*. *See Andrews*, 669 S.E.2d at 313 (citing *Ahlborn*, 547 U.S. at 288 n.18). In the opinion of the Court, Justice Stevens was addressing a danger suggested by proponents of full reimbursement that parties would manipulate settlement agreements reducing the allocation to the medical expense component and thereby diminishing the proportional reimbursement to the state. *Ahlborn*, 547 U.S. at 288. Justice Stevens pointed out that this risk could be avoided either by obtaining a state's advance consent to the allocation or by requiring that the allocation be submitted to the

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. if I or anyone listed on this application is involved in any accident.

J.A. 82 (emphases added).

court. *Id.* In footnote 18, Justice Stevens noted that "[a]s one amicus observes, some States have adopted special rules and procedures for allocating tort settlements . . . . Although we express no view on the matter, we leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation." *Id.* at n.18 (citing Brief of the Association of Trial Lawyers of America as *Amicus Curiae* in Support of Respondents at 20-21) (hereafter "ATLA Brief").

We are not persuaded that a mere "reasonable cap" on a state's recovery from an unallocated lump-sum settlement satisfies the federal anti-lien law as required by *Ahlborn*. Indeed, contrary to the *Andrews* court's reliance on Justice Stevens's footnote, the ATLA Brief, rather than advocating full recovery subject only to a statutory cap, discussed procedures in several states to have "mini-hearings" to set allocations of proceeds from tort settlements where there is no agreement among the interested parties. Nevertheless, the Supreme Court of North Carolina found that footnote 18 in *Ahlborn* authorizes the states to mandate full recovery up to a legislatively-determined, across-the-board limit or cap. This reliance is misplaced.

It is also illuminating that the Centers for Medicaid and Medicare Services ("CMS") issued a memorandum to all Associate Regional Administrators for Medicaid and State Operations in the wake of the *Ahlborn* decision to aid the states in

understanding the effect the decision would have on state third-party liability recovery. *See* Memorandum from Gale Arden, Director of CMS's Center for Medicaid and State Operations Disable and Elderly Health Programs Group (DEHPG) to all Associate Regional Administrators for Medicaid and State Operations, "State Options for Recovery Against Liability Settlements in Light of U.S. Supreme Court Decision in *Arkansas Department of Human Services v. Ahlborn*" (July 3, 2006) (hereafter "CMS Memorandum"). The CMS Memorandum stated that, post-*Ahlborn*, "if a State attempted to recover from more than the portion of a settlement that the parties allocated to medical items and services, it was in violation of the federal anti-lien statute." *Id.* Additionally, the CMS Memorandum clarified that, "to the extent State laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws." *Id.*

To aid states in ensuring compliance with *Ahlborn*, the CMS Memorandum listed various actions states may and may not take: (1) states may only require assignment of the right to payment from a third party for healthcare (or medical) items and services; and (2) states may not pass or enforce laws which broaden the recovery rights, vis-à-vis Medicaid beneficiaries, of the state Medicaid agency, allowing such agencies to recover from damages other than medical expenses provided for in the award amount, even if this means that Medicaid must forego full

recovery of its claim.[11] On the other hand, a state may wish to, *inter alia*: (1) "enact laws which provide for a specific allocation amongst damage[s], i.e., pain and suffering, lost wages, and medical claims"; (2) "require that cases can only be compromised with the consent of the state"; (3) "pass laws which require a mandatory joinder of a State when a Medicaid lien is at issue"; (4) "strengthen their laws regarding the duty of attorneys to notify and cooperate to include provisions which could render voidable any settlement of which the State was not notified and given an opportunity to present its recovery claim for medical assistance paid." *Id.* In addition, the CMS Memorandum emphasized the *Ahlborn* Court's admonition that states should become involved in the underlying tort litigation in order to influence the amount that is allocated in a settlement to medical items and services. *Id.* (stating that "absent such involvement, the Court found little sympathy in the State's argument that they should be able to recover the total settlement").

Indeed, in reaction to the Supreme Court's ruling in *Ahlborn*, many states that previously imposed

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[11] The unrebuttable presumption created by N.C. Gen. Stat. § 108A-57, in the form of a statutory one-third cap on the state's third-party liability recovery against a Medicaid recipient's tort settlement, clearly falls into this category.

statutory caps on Medicaid third-party recovery amended their laws in various ways. Most notably, California changed its laws from imposing a statutory cap of one-half of the recovery to limiting recovery to the portion of the award specifically representing payment for medical expenses or care. Petition for Writ of Certiorari at 20-23, *Brown*, 129 S. Ct. 2792 (No. 08-1146) (discussing Cal. Well'. & Inst. Code § 14124.76). Prior to *Ahlborn*, Pennsylvania's third-party liability statute imposed a fifty percent cap on the state's recovery. *Id.* at 23-24 (discussing 62 Pa. Cons. Stat. Ann. § 1409); *See infra* pp. 35-36 (discussing *Tristani*, 652 F.3d 360). In the wake of *Ahlborn*, however, the Pennsylvania legislature enacted Pa. Cons. Stat. Ann. § 1409.1, which provides *inter alia* that "the court or agency shall allocate the judgment or award between the medical portion and other damages . . ." Similarly, Oklahoma amended its statute to provide that the state's lien extends to the entire settlement, after attorneys fees and costs, unless a more limited allocation of damages to medical expenses is shown by clear and convincing evidence. *Brown*, 129 S. Ct. at 24 (discussing Okla. Stat. Ann. tit. 63, § 5051.1(D)(1)(d)) (internal quotation marks omitted). *Id*aho continues to use its pre-*Ahlborn* statute, which allows for full payment to Medicaid prior to payment of other expenses. *Id.* at 26-27 (discussing Idaho Code Ann. § 56-209b(6)). Post-*Ahlborn*, however, this statute has been interpreted to include a rebuttable presumption of such full payment when an allocation is agreed upon

by the parties (including the state agency) or is determined through a hearing. *Id.* at 27 (citing *State Dep't of Health & Human Welfare v. Hudelson*, 196 P.3d 905, 912 (*Id*aho 2008)). States that continue to impose a statutory cap or allow full recovery for Medicaid reimbursements post-*Ahlborn* include Florida, Georgia, Hawaii, Iowa, and North Carolina. *Id.* at 17; *see* Fla. Stat. Ann. §§ 409.910(1), (4), (6)(a); Ga. Code Ann. § 49-4-149(d); Haw. Rev. Stat. Ann. § 346-37(d); Iowa Code Ann. § 249A.6; N.C. Gen. Stat. § 108-57(a).

(3)

On the basis of *Ahlborn*'s clear holding that the general anti-lien provision in federal Medicaid law prohibits a state from recovering any portion of a settlement or judgment not attributable to medical expenses, DHHS's lien on E.M.A.'s settlement proceeds in this case violates federal law. In order to comply with 42 U.S.C. §§ 1396a(a)(18), 1396p, and *Ahlborn*, North Carolina is free to implement a process by which settlement proceeds are explicitly allocated or otherwise determined. In this case, we must remand for an evidentiary hearing consistent with this opinion to determine the proper amount of the DHHS lien on E.M.A.'s settlement proceeds.

Just as there is insufficient information before this court regarding allocation of the settlement proceeds among various categories of damages, we cannot apply the "proportional analysis" that E.M.A.

argues is proper under *Ahlborn*. As discussed above, the parties in *Ahlborn* stipulated that the settlement of $550,000 represented only one-sixth of the true value of Ahlborn's claim, because the settlement was limited due to the amount of insurance available, and determined that the state was thereby entitled to only one-sixth of the stipulated medical expenses. E.M.A.'s settlement is distinguishable in that there was no issue (so far as the record before us shows) of limited insurance and no stipulation. On remand, the district court must determine the true value of the case in allocating medical expenses, but *Ahlborn* does not mandate such a "proportional analysis," to use the term that Appellants have coined in their briefing.[12]

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[12] In an analogous case arising under post-*Ahlborn* Oklahoma law, the Tenth Circuit has helpfully indicated the kind of considerations that might be salient in assessing the propriety of a particular lien determination:

> [A] reduction in a Medicaid lien can be justified only by showing a reason why the plaintiff would agree to allow the defendant to pay less than the full amount of the Medicaid lien. The usual reasons would be that the liability of the settling defendant is uncertain or that the defendant lacks the money to pay for his full liability (or both); so the plaintiff would be willing to take a proportionate reduction in each component of the damages that she would

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In reaching the conclusion we do, we find the Third Circuit's analysis of the analogous provisions of Pennsylvania law particularly persuasive in our disposition of this appeal. *See Tristani*, 652 F.3d 360. Although the Third Circuit found that the Pennsylvania statutory presumption that fifty percent of a settlement amount was properly allocable to medical expenditures may be deemed to fall within

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> expect the jury to award if the defendant were found liable. For example, if the settlement is for 50% of what the jury is likely to award because there is only a 50% chance that the jury will find liability, the Medicaid lien could properly be cut in half. Or if liability is clear and the expected verdict would be $2 million, but the defendant can pay only $1 million, a 50% reduction would also be in order. A further reduction might also be appropriate if there are doubts about whether the jury would award as damages all the medical expenses paid by Medicaid-because, for example, one could question whether the expenses were caused by the negligent acts of the defendant-although generally one can be more confident of recovering those expenses in full than in recovering, say, the full claim for pain and suffering.

Price v. Wolford, 608 F.3d 698, 707-08 (10th Cir. 2010).

the acceptable "special rules and procedures" contemplated by *Ahlborn* in footnote 18, it cautioned the state that it must afford a mechanism permitting beneficiaries to rebut such a presumption,[13] reasoning as follows:

> Although the *Ahlborn* Court acknowledged the existence in state law of "special rules and procedures" for allocating settlements, and left open the possibility that such rules may be employed to address concerns about settlement manipulation, 547 U.S. at 288 n.18, it did not give states unfettered discretion to allocate settlements without regard to the actual portion attributable to medical expenses. Indeed, *Ahlborn* expressed a preference for resolving allocation disputes "either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Id.* at 288.

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[13] Indeed, the Pennsylvania legislature had amended that state's law after *Ahlborn* precisely to provide such a mechanism, there, an administrative hearing. *See Tristani*, 652 F.3d at 377-78. Nevertheless, the *Tristani* court was required to address an earlier version of the state law because one of the state claims to reimbursement at issue pre-dated the legislative change. *Id.*

> We express no view as to whether allocation disputes of this type must be adjudicated by a court, or may instead be resolved through other "special rules and procedures." *Id.* at 288 n. 18. We hold merely that in determining what portion of a Medicaid beneficiary's third-party recovery it may claim in reimbursement for Medicaid expenses, the state must have in place procedures that allow a dissatisfied beneficiary to challenge the default allocation. As the Beneficiaries point out, without such a rule nothing would prevent states from allocating 75%, 90% or even 100% of a settlement to medical expenses, thereby eviscerating the rule promulgated by *Ahlborn*. Because the District Court concluded otherwise, we will reverse its order in this respect and remand for further proceedings consistent with this opinion.

Id. at 378.

We agree with the reasoning of the Third Circuit and hold that to comport with federal law as interpreted in *Ahlborn*, under the circumstances in this case, North Carolina's statutory presumption must be subject to adversarial testing.[14] Under the

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[14] Notably, in its opinion in this case, the district court cited, in support of its narrow reading of the

circumstances of the case before us, absent any state-created mechanism for such testing, it will fall to the district court to conduct the appropriate proceedings.

V

In sum, E.M.A.'s argument that DHHS cannot assert a lien against her portion of the settlement proceeds because a minor has no cause of action for past medical expenses under North Carolina common law fails because the state Medicaid statutes at issue fully abrogate the common law. Nevertheless, we hold that the North Carolina third-party liability statutes, N.C. Gen. Stat. §§ 108A-57 and -59, as applied in this case, fail to comply with federal Medicaid law as interpreted by the Supreme Court in *Ahlborn*. As the unanimous *Ahlborn* Court's decision makes clear, federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to past medical expenses. In the event of an unallocated lump-sum settlement exceeding the

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Ahlborn holding, the lower court's decision in *Tristani*. *See Armstrong*, 722 F. Supp. 2d at 658 (citing *Tristani v. Richman*, 609 F. Supp. 2d 423, 464-65 (W.D. Pa. 2009)). But, as just discussed, on appeal, the Third Circuit specifically reversed that portion of the lower court's judgment in *Tristani* that had rejected the need for adversary testing of the fifty percent presumption under Pennsylvania law. *See* 652 F.3d at 378.

amount of the state's Medicaid expenditures, as in this case, the sum certain allocable to medical expenses must be determined by way of a fair and impartial adversarial procedure that affords the Medicaid beneficiary an opportunity to rebut the statutory presumption in favor of the state that allocation of one-third of a lump sum settlement is consistent with the anti-lien provision in federal law.

Accordingly, for the reasons set forth, we vacate the judg-ment of the district court and remand for an evidentiary hearing at which the district court shall determine the proper amount of DHHS's Medicaid lien in this case in accordance with *Ahlborn* and the views expressed in this opinion.

VACATED AND REMANDED

AGEE, Circuit Judge, concurring in part, dissenting in part, and concurring in the judgment:

I join the majority opinion except for Section IV(A) (and related references), which concludes that the relevant North Carolina Medicaid statutes, N.C. Gen. Stat. § 108A-59(a) ("the assignment statute") and N.C. Gen. Stat. § 108A-57(a) ("the subrogation statute") abrogate the common law of North Carolina under which a minor has no cause of action for recovery of medical expenses incurred during minority. Accordingly, I respectfully dissent from that portion of the majority opinion and write separately because nothing in either the assignment statute or

the abrogation statute suggest that the General Assembly of North Carolina intended to extend or create such a cause of action. Furthermore, I find no support in the decided cases of the North Carolina appellate courts holding that state's legislature abrogated the otherwise applicable common law rule. Consequently, I would hold the common law rule survives the enactment of North Carolina's Medicaid statutes.[1] Nonetheless, for the reasons discussed below, I would vacate and remand the judgment of the district court.

Unless modified by statute, the common law is the law of North Carolina, as in many states. *See State v. Vance*, 403 S.E.2d 495, 498 (N.C. 1991); N.C. Gen. Stat. § 4-1("All such parts of the common law . . . [as are] not abrogated, repealed, or . . . obsolete, are hereby declared to be in full force within this State."). "When the [North Carolina] General Assembly legislates in respect to the subject matter of

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[1] In resolving this difficult question of the interplay between North Carolina's common law and its Medicaid statutes, it would be helpful to seek guidance from that state's highest court. Unfortunately, unlike the other states in this circuit, North Carolina alone provides no mechanism for us to certify questions of state law to its Supreme Court. *See MLC Automotive, LLC v. Town of Southern Pines*, 532 F.3d 269, 284 (4th Cir. 2008).

a common law rule, the statute supplants the common law rule in regard to that matter." *State v. Green*, 477 S.E.2d 182, 187 (N.C. Ct. App. 1996) (citing *McMichael v. Proctor*, 91 S.E.2d 231, 234 (N.C. 1956)). However, the common law controls unless the legislature expressly abrogates it. *See In re Thompson*, 327 S.E.2d 908, 909 (N.C. Ct. App. 1985); *see also Lowe v. Harris*,17 S.E. 539, 544 (N.C. 1893) (Shepherd, C.J., concurring) ("[I]f the legislature intended to abrogate these [common law] rules, in whole or in part, it should have expressed such intention in the clearest and most unmistakable manner."); *Price v. Edwards*, 101 S.E. 33, 36 (N.C. 1919) ("[S]tatutes in derogation of common law . . are construed strictly.").[2]

Under the common law of North Carolina, a minor has no cause of action against a tortfeasor for medical expenses incurred during minority. *See Vaughan v. Moore*, 366 S.E.2d 518, 520 (N.C. Ct. App. 1988). Rather, the right to recover for medical expenses lies with the parents, but the minor (through his or her proper representative) may

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[2] The common law is incorporated into the North Carolina statutory scheme by N.C. Gen. Stat. § 4-1. North Carolina courts abide by the maxim that "repeal by implication is not a favored rule of statutory construction." *State v. Greer*, 302 S.E.2d 774, 777 (N.C. 1983) (internal quotation marks omitted).

recover for other damages, such as pain and suffering or loss of future income. *Id.* (citing *Ellington v. Bradford*, 86 S.E.2d 925, 926 (N.C. 1955)). Applying that principle to this case, it would appear that E.M.A. could not recover against her tortfeasor for the incurred medical expenses. As a consequence, the principles enunciated in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006), would insulate E.M.A.'s allotted portion of the settlement proceeds from the State's lien unless that portion did in fact include medical expense reimbursements.

Notwithstanding North Carolina common law, however, the majority opinion, relying upon the "plain language" of the subrogation statute and the assignment statute, as well as pre-*Ahlborn* authority, allows the State to encumber E.M.A.'s portion of settlement proceeds. I do not agree the statutes at issue here lead to that result.

The assignment statute states that "[n]otwithstanding any other provisions of the law, by accepting medical assistance, the recipient shall be deemed to have made an assignment to the State of the right to third party benefits . . . to which he may be entitled." N.C. Gen. Stat. § 108A-59(a). The subrogation statute uses similar terms to express that: "[n]otwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, shall be subrogated to all rights of recovery,

contractual or otherwise, of the beneficiary of this assistance . . . ." *Id.*

With particular emphasis on the "[n]otwithstanding any other provisions of the law," language, the majority opinion concludes that these statutes "by their plain language abrogate the common law rule that a minor cannot recover for medical expenses." Maj. Op, at 26. Neither statute, however, conflicts with the common law rule at issue here by its plain terms or otherwise.

The assignment statute specifically limits the "rights" assigned: "the recipient [of Medicaid benefits] shall be deemed to have made an assignment to the state of the right to third party benefits . . . *to which he may be entitled*." (Emphasis added.) By its express language, this statute does not purport to enlarge the preexisting rights of a beneficiary of Medicaid benefits, including those possessed by minors. A plain reading of the statute instead leads to the conclusion that, to the extent a beneficiary of Medicaid benefits has a claim to third party benefits, that beneficiary by operation of law assigns those rights to the state. The statute could have easily been written to create a new cause of action in the Medicaid beneficiary, but it was not. Rather, the statute speaks of the assignment only of the rights, if any, that already exist in the beneficiary.

In this regard, *E.D.B. ex rel. D.B. v. Clair*, 987 A.2d 681 (Pa. 2009), cited *ante* at 28 n.9, is

instructive. In that case, the Supreme Court of Pennsylvania found, pursuant to its state's Fraud and Abuse Control Act (which operates, like the North Carolina Medicaid statutes at issue here, to regulate the state's right of assignment of benefits) "a Medicaid beneficiary has a cause of action against his or her tortfeasor to recover and reimburse [the state] for Medicaid benefits received during the beneficiary's minority." *Id.* at 691.[3] The Pennsylvania statutes at issue did not expressly provide for a cause of action for a minor tort-victim for medical expenses, but rather, Pennsylvania's highest court found that the legislature intended to create such a cause of action in order to effectuate its goal that "the entirety of a beneficiary's settlement would be subject to [the state's] claim." *Id.* at 690. Although that goal was unattainable after *Ahlborn*, the court noted that "nothing in *Ahlborn* affects, negates, weakens, or calls into question the reasoning. . . as to the General Assembly's *intent* with regard to the filing of claims by beneficiaries for Medicaid expenditures incurred during their minority," *Id.* at 691 (emphasis in

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[3] The court in *E.D.B.* found such a cause of action in Pennsylvania's statutes. Its analysis demonstrates, however, that the relevant inquiry is not whether a state had mandated that the minor assign his or her rights to the state, but rather, whether the minor had a recognized right to recover (i.e., a cause of action) and therefore something to assign.

original). The key here, in contradistinction from the statutes or court decisions in North Carolina, is that the Pennsylvania Supreme Court specifically concluded a cause of action existed in a minor, therefore giving the minor a chose to assign.

In stark contrast, North Carolina's Court of Appeals has rejected the notion that the statutes at issue create a cause of action in a minor for medical expenses, even where that minor is a beneficiary of Medicaid benefits. *See Campbell v. N.C. Dep't of Human Res.*, 569 S.E.2d 670, 672 (N.C. Ct. App. 2002) (stating that because, under North Carolina common law, a minor has no cause of action for medical expenses, "the settlement money which [the minor] plaintiff received was not recompense for medical expenses"). *Campbell* thus acknowledged that, even after the enactment of the North Carolina Medicaid statutes, a minor lacked a cause of action for medical expenses, ruling instead that the State was nonetheless entitled to the plaintiff's settlement proceeds on other grounds (although this rationale has since been nullified by *Ahlborn*.

The same is true of North Carolina's subrogation statute which requires that "to the extent of [Medicaid] payments . . . , the State, . . . shall be subrogated to *all rights of recovery* . . . of the beneficiary of this assistance[.]" N.C. Gen. Stat § 108A-57(a) (emphasis added). Again, the statute speaks only of the existing rights of the beneficiary, and simply does not create any new rights to a cause

of action in a minor. E.M.A. cannot assign, nor can the State be subrogated to, rights that she does not possess.

I am also not persuaded that *Ezell v. Grace Hospital, Inc.*, 623 S.E.2d 79 (N.C. Ct. App. 2005), *rev'd per curiam for the reasons stated in the dissenting opinion*, 631 S.E.2d 131 (N.C. 2006), is applicable to E.M.A's argument. That case dealt with the issue of whether common law equitable limitations on recovery could be applied to reduce the State's recovery of third-party benefits paid to a Medicaid beneficiary. *See Ezell*, 623 S.E.2d at 81. *Ezell's* holding that the subrogation statute abrogates common law equitable recovery principles is simply a recognition that application of the common law yields a different result than application of the statutory language. As explained above, that is not the case with the common law rule limiting the minor's right to recovery for medical expenses. *Ezell* says nothing about changing the North Carolina common law rule regarding the cause of action for recovery of a minor's medical expenses.

The majority opinion, however, relies on *Campbell* as additional support for its holding that the common law rule is abrogated. In that case, the North Carolina Court of Appeals considered and rejected a claim similar to that raised by E.M.A. *Ahlborn*, however, which was decided four years after *Campbell*, has clearly eviscerated the rationale of *Campbell* such that its holding should not be entitled

precedential weight.

In *Campbell*, the plaintiff, who was a minor at the time he was injured by a third-party tortfeasor and received Medicaid benefits, claimed that the State had no right of subrogation because he lacked a cause of action under North Carolina law for medical expenses. While agreeing with the premise that, at common law, a minor may not recover for medical expenses incurred during minority, the North Carolina Court of Appeals reasoned that "[N.C. Gen. Stat.] § 108A-57(a) does not restrict [the State's] right of subrogation to a beneficiary's right of recovery only for medical expenses." 569 S.E.2d at 672. Because North Carolina's Medicaid statutes allowed the state to place a lien upon any of the plaintiff's settlement proceeds, regardless of whether they were for medical expenses, the plaintiff's right (or lack thereof) to receive medical expenses in tort was no barrier to the State's lien. The *Campbell* court relied on prior North Carolina cases for the proposition that "to the extent of Medicaid payments under [the] Medical Assistance Program" the State is "subrogated to all rights of recovery of the beneficiary of medical assistance." *Id.* (citing and quoting *N.C. Dept of H.R. v. Weaver*, 466 S.E.2d 717, 719 (N.C. Ct. App. 1996), (emphasis and internal alterations omitted).

Campbell also relied heavily on *Payne v. North Carolina Department of Human Resources*, 486 S.E.2d 469 (N.C. Ct. App. 1997), a case in which the North Carolina Court of Appeals considered and

rejected a challenge to North Carolina's Medicaid subrogation scheme based on the federal anti-lien statute found at 42 U.S.C. § 1396p(a)(1). *Campbell* described the *Payne* holding as follows:

> Plaintiff [in *Payne*] argued that [the State's] subrogation rights extended only to the amount allocated to his mother for medical expenses. This Court disagreed, and held that "by accepting Medicaid benefits, [minor plaintiff] assigned his right to third-party benefits to [the State], and [the State's] lien vested at that time."

Campbell, 569 S.E.2d at 672-73.

This reasoning is plainly at odds with *Ahlborn's* command that a state Medicaid agency may not seek assignment of "rights to payment for anything other than medical expenses-not lost wages, not pain and suffering, not an inheritance." *Ahlborn*, 547 U.S. at 281.[4]

Accordingly, when the *Campbell* court opined that

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[4] The fact that, pre-*Ahlborn*, the *Campbell* and *Payne* courts permitted a Medicaid lien regardless of the medical expense portion of tort recovery, combined with the statutory percentage limit, may explain why the particular issue now raised by E.M.A. had not previously been raised or addressed by the North Carolina courts post-*Ahlborn*.

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"[the State] is entitled to recover the costs of medical treatment provided for a minor, even when the funds received by the minor are not reimbursement for medical expenses[,]" 569 S.E.2d at 672, its rationale conflicts directly with *Ahlborn*. *See* 547 U.S. at 282 ("[T]he State's assigned rights extend only to recovery of payments for medical care."). While it is true that most creditors can usually satisfy debts owing to them from any assets of the debtor that the creditor can find, this is not the case in the Medicaid context. *Ahlborn* and the federal anti-lien statute at 42 U.S.C. § 1396p make clear that a state Medicaid lien can only be levied against those assets received for medical expenses.

> There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§ 1396a(a)(25) and 1396k(a). . . . To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. *But that does not mean that the State can force an assignment of or place a lien on, any other portion of Ahlborn's property.*

Ahlborn, 547 U.S. at 284-85 (internal citations omitted) (emphasis added). *Campbell*, which stands in obvious conflict with that holding, must give way and cannot be a basis upon which to find abrogation

of the North Carolina common law rule.

Indeed, the one aspect of *Campbell* that seems to survive *Ahlborn* is the acknowledgement of the North Carolina common law that because "a minor, even after reaching majority, may not recover for medical expenses incurred during minority. . . *the settlement money which plaintiff received was not recompense for medical expenses.*" 569 S.E.2d at 672 (internal citation and quotation marks omitted) (emphasis added). That statement of North Carolina law does not rest on a premise that has been rejected by the Supreme Court, and should guide our analysis of E.M.A.'s claim on appeal. It is a recognition that, even in light of North Carolina's Medicaid statutes, a minor still lacks a cause of action for medical expenses. Accordingly, the argument that the North Carolina Medicaid subrogation and assignment statutes somehow abrogate this right is not an accurate statement of North Carolina law in my view.

I therefore must disagree with the conclusion in the majority opinion that the North Carolina Medicaid statutes "by their plain language" abrogate the common law. Maj. Op. at 26. And, as noted above, no North Carolina appellate court decision, in conformity with *Ahlborn*, so construes those statutes. To the contrary, the statutes at issue plainly do not conflict with, and nor do they abrogate, the common law rule that minors may not recover for medical expenses in North Carolina.

Nevertheless, while the minor does not have a

cause of action for medical expenses, that does not necessarily mean, in an otherwise unallocated settlement, that none of the funds comprising the minor's share were not in fact representative of medical expenses already incurred or allocated to a Special Needs Trust ("SNT") in anticipation of medical expenses to be incurred in the future. A competent advocate for a minor in structuring such a settlement would, knowing the North Carolina common law, attempt to have allocated as much as possible of a fixed settlement to the minor's share, irrespective of what categories of damages comprise the settlement amount. That allocation would be of little moment to the tortfeasor, whose only interest is in release from liability. The record before the court in the case at bar simply does not allow us to determine whether E.M.A.'s settlement share did include an amount actually represented by the medical expense damages.

The state trial court order approving the settlement does not make the findings necessary to resolve to what extent the Medicaid lien, under *Ahlborn*, is applicable here. I do not fault the state trial judge as there was (like now) no clear rule by appellate decision or legislative enactment on point. If the matter of medical expense reimbursement was part of the calculation put before the state trial court, and the settlement order stated how an allocation between the parties was determined with the damage elements comprising each share, then the determination as to what could be attached by the

OPINION OF THE 4TH CIRCUIT COURT OF APPEALS, DECIDED MARCH 22, 2012

Medicaid lien should be straightforward. Such an explicit allocation is not in the record before us, however. It is simply not possible, on this record, to ascertain what elements of damages comprise the respective settlement shares of E.M.A. or her parents. For that reason I agree with the majority that the district court judgment must be vacated and remanded. Should it be determined, on remand, that any portion of E.M.A.'s settlement share was in fact represented by her past medical expenses, then the State's Medicaid lien could properly attach to that portion under *Ahlborn*. However, should it be determined that no part of E.M.A.'s share was represented by her past medical expenses, no lien could attach.

On remand, the district court should consider two salient questions:

1. What amount of the settlement was allocated to each party: (a) E.M.A. (acting through her guardian ad litem); and (b) Earl and Sandra Armstrong (E.M.A.'s parents)?

2. What elements of damage comprise the award each party received? Put another way, were the respective amounts awarded on an ad hoc or arbitrary determination or was there an actual basis for the division between the parties based on the merits of the various elements of damage, such as medical expenses?

Although cases that have approved the default

statutory percentage method for allocating settlement proceeds did so partly on the basis to avoid a case-by-case determination of the medical expense portion of settlements, *e.g.*, *Andrews v. Haygood*, 669 S.E.2d 310, 314 (N.C. 2008), I agree with the majority opinion that *Ahlborn* requires such fact-specific inquiries in a case such as is now before us. Until states develop a specific mechanism for determining the medical expense portion of unallocated settlements, a judicial resolution is the only means by which the *Ahlborn* principles for application of a Medicaid lien can be established. The Supreme Court seemed to recognize this point in *Ahlborn* that determining Medicaid lien status on an allocated or unallocated settlement could be "either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Ahlborn*, 547 U.S. at 288.

I am in agreement with the majority opinion's conclusion that "[t]he North Carolina statute's one-third cap on the state's recovery against a Medicaid recipient's settlement proceeds does not satisfy *Ahlborn* insofar as it permits DHHS to assert a lien against settlement proceeds intended (or otherwise properly allocable) to compensate the Medicaid recipient for other claims[.]" Maj. Op. at 30. While I disagree that North Carolina has abrogated its common law rule that minors have no cause of action for medical expenses, I do agree a remand is necessary in order for the district court to determine whether E.M.A. actually received any settlement

funds for medical expenses, and if so, how much.

For the foregoing reasons, I respectfully dissent from Section IV(A) (and related references) of the majority opinion, but concur otherwise and concur in the judgment.

MEMORANDUM OF THE UNITED STATES DISTRICT COURT, W.D.N.C., DECIDED JUNE 28, 2010

APPENDIX B

[E.M.A.], a minor, by and through her Guardian ad Litem, WILLIAM W. PLYLER,[1] WILLIAM E. ARMSTRONG, and SANDRA ARMSTRONG,
Plaintiffs / Counter-Defendants,

vs.

LANIER M. CANSLER, in his official capacity as Secretary of the North Carolina Department of Health and Human Services,[2]
Defendant / Counter-Plaintiff.

CIVIL DOCKET NO. 5:07-CV-37-RLV

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NORTH CAROLINA
STATESVILLE DIVISION

722 F. Supp. 2d 653; 2010 U.S. Dist. LEXIS 63966

June 28, 2010, Decided

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[1] Effective October 2, 2009, William W. Plyler was appointed and substituted for Stephanie J. Gibbs as guardian ad litem for Emily Armstrong. (Document #24.)

[2] Effective January 28, 2009, Lanier M. Cansler replaced the originally named Defendant, Carmen Hooker Odom, as Secretary of the North Carolina Department of Health and Human Services. (Document #14.)

MEMORANDUM OF THE UNITED STATES DISTRICT COURT, W.D.N.C., DECIDED JUNE 28, 2010

June 28, 2010, Filed

SUBSEQUENT HISTORY: Judgment entered by Armstrong v. Cansler, 2010 U.S. Dist. LEXIS 63958 (W.D.N.C., June 28, 2010)
Vacated by, Remanded by E.M.A. v. Cansler, 2012 U.S. App. LEXIS 5996 (4th Cir. N.C., Mar. 22, 2012)

PRIOR HISTORY: Armstrong v. Cansler, 2009 U.S. Dist. LEXIS 49725 (W.D.N.C., June 1, 2009)

COUNSEL: [**1] For Emily M. Armstrong, a minor, by and through her Guardian ad Litem, William W. Plyler, Plaintiff, Counter Defendant: C. Mark Holt, LEAD ATTORNEY, Kirby & Holt, LLP, Raleigh, NC; William Webb Plyler, LEAD ATTORNEY, McMillan Smith & Plyler, Raleigh, NC; Jeffrey Thomas Mackie, Sigmon, Clark, Mackie, Hutton, Hanvey & Ferrell, PA, Hickory, NC; William B Bystrynski, Raleigh, NC.

For William Earl Armstrong, Sandra Armstrong, Plaintiffs: C. Mark Holt, LEAD ATTORNEY, Kirby & Holt, LLP, Raleigh, NC; Jeffrey Thomas Mackie, LEAD ATTORNEY, Sigmon, Clark, Mackie, Hutton, Hanvey & Ferrell, PA, Hickory, NC; William B Bystrynski, LEAD ATTORNEY, Raleigh, NC.

For Lanier M. Cansler, in his official capacity as Secretary of the North Carolina Department of Health and Human Services, Defendant, Counter Claimant: Belinda A. Smith, Susannah Porter Holloway, LEAD ATTORNEYS, N.C. Department of Justice, Raleigh, NC.

MEMORANDUM OF THE UNITED STATES DISTRICT COURT, W.D.N.C., DECIDED JUNE 28, 2010

For Emily M. Armstrong, a minor, by and through her Guardian ad Litem, William W. Plyler, Counter Defendant: William Webb Plyler, LEAD ATTORNEY, McMillan Smith & Plyler, Raleigh, NC.

JUDGES: Richard L. Voorhees, United States District Judge.

OPINION BY: Richard L. Voorhees

OPINION

[*654] **Memorandum and Order**

THIS MATTER is before the [**2] Court on cross-motions for summary judgment and all related memoranda of law and exhibits offered in support and opposition. (Documents # 25, # 28.)

I. Background

This case arises out of the Complaint filed on March 23, 2007 on behalf of the minor child, Emily M. Armstrong. Plaintiff brings the action under 42 U.S.C. § 1983 seeking declaratory and injunctive relief for the deprivation of her rights, as secured by 42 U.S.C. § 1396p (known as the "Federal Medicaid Anti-Lien Provision") and the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution. In the Complaint, Plaintiff requests a declaratory judgment finding: 1) that Defendant does not have a lien on the proceeds arising from the minor child's personal injury action against James A. Barnes,

Jr., M.D., Newton Women's Care, P.A., and Catawba Valley Medical Center ("the underlying action"); 2) that N.C. Gen. Stat. §§ 108A-57 and 108A-59 are unconstitutional to the extent that the statutes allow Defendant to assert a lien on compensation for damages other than medical expenses pursuant to the Supremacy Clause; and 3) that Defendant be enjoined from enforcing N.C. Gen. Stats. §§ 108A-57 and 108A-59 in a [**3] manner that violates 42 U.S.C. § 1396, *et seq.*, *Arkansas Dep't of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006), and the Equal Protection Clause of the Fourteenth Amendment.

On April 22, 2008, the Court heard oral argument on Defendant's Motion to Dismiss for Lack of Subject Matter Jurisdiction and Motion To Dismiss pursuant to Rule 12(b)(6) as to Plaintiff's Equal Protection claim. (Document # 7.) By oral Order, the Court denied Defendant's Rule 12(b)(1) motion and granted its 12(b)(6) motion without prejudice. The Court also stayed all Rule 16 discovery obligations pending disposition in the North Carolina Supreme Court of the *Andrews v. Haygood* appeal. *See Andrews v. Haygood*, 188 N.C. App. 244, 655 S.E.2d 440 (N.C. Ct. App. 2008).

On May 1, 2008, Defendant filed its "Answer, Affirmative Defense, Counterclaim, and Motion to Dismiss." (Document # 12.) Defendant asserts estoppel as its first affirmative defense, arguing that Plaintiff's current contention that North Carolina Department of

MEMORANDUM OF THE UNITED STATES DISTRICT COURT, W.D.N.C., DECIDED JUNE 28, 2010

Health and Human Services is not entitled to any of the recovered funds is inconsistent with her previous statements in the state court proceedings. In its counterclaim, Defendant seeks a declaratory judgment [**4] that N.C. Gen. Stats. §§ 108A-57 and 108A-59 are constitutional. Finally, Defendant's filing includes a Rule 12(b)(7) Motion to Dismiss for Plaintiff's failure to join her parents, who Defendant alleges are necessary and indispensable parties.

On January 13, 2009, Plaintiff filed a "Notice in Compliance with Court's Order," advising the Court of the North Carolina Supreme Court's decision in *Andrews v. Haygood*, 362 N.C. 599, 669 S.E.2d 310 (2008). (Document # 13.) Accordingly, the Court issued an Order on June 1, 2009, lifting the stay on discovery obligations. (Document # 15.) In the Order, the Court also referred the parties to Local Civil Rules 7.1(C)(1) [*655] and 16.1(D)[3], the effect of which was to direct the parties to proceed with an Initial Attorney's Conference, submit the Certification of Initial

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[3] Pursuant to Local Civil Rule 7.1(C)(1): "Motions to dismiss contained in answers to complaints . . . are considered by the Court to be preserved. A party wishing to have decided any preserved motion shall file a separate motion and supporting brief." In addition, Local Civil Rule 16.1(D) [**5] explains as follows: "Rule 12 motions contained in an Answer, but not supported by a brief, act as placeholders and do not prevent joinder of the issues."

Attorney's Conference, and brief the central legal issue presented -- cognizability of Plaintiff's claim in light of the *Andrews* decision.

On July 6, 2009, Plaintiff filed an Amended Complaint adding William E. Armstrong and Sandra Armstrong as Plaintiffs. (Document # 19.)

On October 15, 2009, both parties moved for summary judgment, and these motions are now ripe for disposition by the Court.

II. Standard of Review

When faced with cross-motions for summary judgment, the court must apply the customary standard and review each motion separately on its own merits. *Rossignol v. Voorhaar*, 316 F.3d 516, 523 (4th Cir. 2003). Summary judgment is appropriate when "there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." *Fuisz v. Selective Ins. Co. of Am.*, 61 F.3d 238, 241 (4th Cir. 1995); *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986). All permissible inferences to be drawn from the facts are to be viewed in the light most favorable to the party opposing the motion. *Miller v. Fed. Deposit Ins. Corp.*, 906 F.2d 972, 974 (4th Cir. 1990); *Matsushita*, 475 U.S. at 587-88. However, where the record [**6] taken as a whole "could not lead a rational trier of fact to find for the non-moving party, disposition by summary judgment

is appropriate." *Miller*, 906 F.2d at 974; *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986). Whether a complaint states a cognizable claim is a legal question dependent on the applicable law, not an issue of fact upon which disagreement would prevent summary judgment. *See Loe v. Armistead*, 582 F.2d 1291, 1295 (4th Cir. 1978).

III. Discussion

In filing cross-motions for summary judgment, the parties dispute the impact of two recent decisions on the North Carolina statutory scheme for Medicaid reimbursement. Plaintiffs contend that the holding of the Supreme Court of the United States in *Arkansas Dep't. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006) is controlling on this matter. (Pl.'s Memo. Supp. Mot. for Summary Judg., 4.) According to Plaintiffs, the North Carolina statutes are inconsistent with federal law as interpreted in *Ahlborn*; thus, this Court should disregard the contrary decision of the North Carolina Supreme Court in *Andrews v. Haygood*, 362 N.C. 599, 669 S.E.2d 310 (2008). (Pl.'s Memo. Supp. Mot. for Summary Judg., 9.) On the other hand, Defendant [**7] maintains that the Court should give *Andrews* dispositive effect, holding that the Medicaid recovery statutes comport with *Ahlborn*, and as a consequence, grant Defendant's Motion for Summary Judgment. (Def.'s Memo. Supp. Mot. for Summary Judg., 8.)

MEMORANDUM OF THE UNITED STATES DISTRICT COURT, W.D.N.C., DECIDED JUNE 28, 2010

Although the decision in *Andrews* is not binding on this Court, as Plaintiffs rightly assert, (Pl.'s Memo. Supp. Mot. for Summary Judg., 9) for the forthcoming reasons, the Court holds that the North [*656] Carolina Supreme Court was correct in determining that the North Carolina statutes are consistent with federal Medicaid law as construed in *Ahlborn*. *See Andrews*, 362 N.C. at 605. Therefore, Plaintiff's opposing claims are denied, and with no genuine issue of material fact remaining, Defendant is entitled to summary judgment.

In *Ahlborn*, the Supreme Court of the United States addressed a challenge to the Arkansas Medicaid reimbursement statute. 547 U.S. at 280. That statute permitted the Arkansas Department of Health and Human Services to recover "to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant." *Id.* at 277. Ahlborn, a Medicaid recipient, appealed the statute because it did not limit reimbursement to [**8] ADHS to settlement proceeds stipulated as recovery for medical expenses. *Id.* at 274. Although the State had stipulated "that only $35,581.47 of [the settlement] sum represent[ed] compensation for medical expenses," it asserted a lien for $215,645.30. *Id.* at 280. The Supreme Court rejected the State's claim of "absolute priority," *id.* at 288, and held that the Arkansas statute did not comport with federal law. *Id.* at 284. According to the Court, 42 U.S.C. §§ 1396a(a)(25) and 1396k(a) are exceptions to the federal anti-lien provision, authorizing the State "to demand as a condition of

Medicaid eligibility that the recipient 'assign' in advance any payments that may constitute reimbursement for medical costs." *Id.* However, to the extent that the Arkansas statute allowed the State to impose a lien beyond the portion of the settlement allocated to medical care, it violated the anti-lien provision in § 1396p(a). *Id.*

Two years later, in *Andrews*, the North Carolina Supreme Court properly concluded that *Ahlborn* did not bar implementation of the North Carolina statutory scheme. 362 N.C. at 604. The court's decision was based on a determination that the *Ahlborn* holding was limited to a proscription [**9] against the State receiving reimbursement in excess of the portion expressly stipulated as recovery for medical expenses in a Medicaid recipient's settlement with a third-party. *Id.* at 603. In *Ahlborn*, the Supreme Court did not, however, require "a specific method for determining the portion of a settlement that represents the recovery of medical expenses." *Id.* Thus, the *Andrews* court inferred that a State may adopt a statutory method for making this determination in the absence of a prior judicial allocation. *Id.* N.C.G.S. § 108A-57(a) is designed to do precisely that in North Carolina, by "defin[ing] 'the portion of the settlement that represents payment for medical expenses' as the lesser of the State's past medical expenditures or one-third of the plaintiff's total recovery." *Id.* at 604. By limiting the State's subrogation right to one-third of a Medicaid recipient's recovery, the scheme "protects plaintiffs' interests while promoting efficiency in Medicaid

reimbursement cases throughout North Carolina." *Id.* Accordingly, the court upheld the law as a permissible framework within the federal Medicaid requirements. *Id.* at 605. On June 15, 2009, the plaintiff's petition for certiorari [**10] was denied by the Supreme Court of the United States. *Brown v. N.C. Dep't of Health and Human Servs.*, 129 S. Ct. 2792, 174 L. Ed. 2d 291 (2009).

In addition to the analysis in *Andrews*, this Court's independent examination of the North Carolina scheme governing Medicaid reimbursement reveals that Plaintiffs' argument of a conflict between [*657] the State's statutes and federal law is without merit. Under 42 U.S.C. § 1396a, funding from the federal Medicaid program is conditioned on the adoption of a state plan that conforms to specific federal requirements. Participating states are required to "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan," and to "seek reimbursement for assistance to the extent of such legal liability." 42 U.S.C. § 1396a(a)(25)(A)-(B). North Carolina has complied by enacting the State Plan for Medical Assistance, which includes an assignment statute, N.C.G.S. § 108A-59, and a subrogation statute, § 108A-57. Implementation of a Medicaid recipient's statutory assignment is governed by N.C.G.S. §108A-57(a) which provides:

> Any attorney retained by the beneficiary of the assistance shall, out of the proceeds [**11]

> obtained on behalf of the beneficiary by settlement with . . . a third party . . . distribute to the Department the amount of assistance paid by the Department . . . but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.

Accordingly, in the absence of a judicial allocation,[4] North Carolina has determined that the State may only recover "the lesser of the State's past medical expenditures or one-third of the plaintiff's total recovery." *Andrews*, 362 N.C. at 604. The lesser of these two amounts essentially defines "the portion of the settlement that represents payment for medical expenses" in cases, such as this matter, involving a lump-sum settlement. *Id.* By preventing the State from obtaining more than this portion of a Medicaid

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[4] *Ahlborn* controls "when there has been a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement. In those cases, the State may not receive reimbursement in excess of the portion so designated." *Andrews*, 362 N.C. at 603. This Court is addressing the question of whether the State may adopt a statutory method for making that determination in cases lacking a prior judicial allocation. It appears clear that the State may do so, "[n]onetheless, plaintiffs are free to negotiate a settlement with the State for a lien amount less than that required by [the] statutes." *Id.* at 604.

recipient's settlement, regardless of whether the State in fact provided more assistance, the North Carolina statute avoids the conflict at issue in *Ahlborn*. The Arkansas reimbursement statute violated the federal anti-lien provision because it permitted the State to impose a lien beyond the portion of a settlement allocated to medical care. *Ahlborn*, 547 U.S. at 284. Meanwhile, N.C.G.S. § 108A-57(a) provides [**12] a means of calculating that portion, and then forbids the State from imposing a lien on the remainder of the settlement.

Moreover, the North Carolina scheme alleviates another critical concern expressed by the Supreme Court in *Ahlborn* regarding Medicaid reimbursement. In reviewing the previous Arkansas system, the Supreme Court was particularly disconcerted by the absence of a limit on the State's recovery. *See Ahlborn*, 547 U.S. at 278. Thus, if the State had provided substantial assistance to a Medicaid recipient, beyond the amount the individual obtained in a third-party settlement, [**13] ADHS could recover the entire settlement and leave the plaintiff with nothing. *Id.* On the other hand, N.C.G.S. § 108A-57(a) prevents a Medicaid recipient from incurring such a hardship in the North Carolina system. Section 108A-57(a) "allows total reimbursement to the State only when 'the amount of assistance' previously paid for medical expenses is one-third of the plaintiff's settlement or less." *Andrews*, 362 [*658] N.C. at 604. Accordingly, there is no concern of "excessive depletion of a plaintiff's recovery to satisfy the State's

reimbursement lien." *Id.* The one-third ceiling is a fair balance, "providing a reasonable method for determining the State's medical reimbursements, which it is required to seek in accordance with federal Medicaid law," while also protecting the recipient's interests. *Id.*

For similar reasons, courts have recently upheld Florida's nearly identical Medicaid reimbursement statute as comporting with federal law. *See e.g., Russell v. Agency for Health Care Admin.*, 23 So.3d 1266 (Fla. 2d DCA 2010); *Scharba v. Everett L. Braden, Ltd.*, 2010 U.S. Dist. LEXIS 40200 (M.D. Fla. Mar. 31, 2010). The Second District Court of Appeal of Florida determined, as the North Carolina [**14] Supreme Court did, that "[c]entral to the *Ahlborn* court's reasoning was the state's stipulation concerning the portion of the settlement attributable to medical expenses." *Russell*, 23 So.3d at 1268. Under *Ahlborn*, the State may not impose a lien beyond that portion in cases in which an allocation is expressly stipulated; however, the Second District Court of Appeal held that where the parties to a settlement have not agreed on an allocation for recovery of medical costs, Florida's statutory fifty-percent rule governs. In those cases, the State recovers the lesser amount of the past Medicaid assistance provided to the plaintiff or one-half of the plaintiff's total settlement. *See id* at 1267-69 (affirming that *Ahlborn* did not apply, and upholding Florida's fifty-percent allocation statute as a permissible framework under federal Medicaid law).

MEMORANDUM OF THE UNITED STATES DISTRICT COURT, W.D.N.C., DECIDED JUNE 28, 2010

The persuasive reasoning employed by the Florida courts simply provides further support for this Court's judgment regarding North Carolina's statutory scheme. The only distinguishing fact from the Florida law in the North Carolina statute is that the State's reimbursement is capped at a lower percentage of a recipient's recovery. N.C.G.S. § 108A-57(a) [**15] provides a more conservative assessment of medical costs in the absence of judicial allocation, rendering it actually more protective of plaintiffs than the Florida statute recently affirmed as consistent with *Ahlborn*.

For the foregoing reasons, the Court concludes that the North Carolina Medicaid recovery statutes, §§ 108A-57 and 108A-59, comport with federal law as interpreted in *Ahlborn*. If a Medicaid recipient in North Carolina obtains a third-party lump-sum settlement, which does not allocate a specific portion to recovery for medical costs, § 108A-57(a) controls. Accordingly, the State will be reimbursed "the lesser of the State's past medical expenditures or one-third of the plaintiff's total recovery." *Andrews*, 362 N.C. at 604. The Supreme Court acknowledged in *Ahlborn* that "some States have adopted special rules and procedures for allocating tort settlements" under certain circumstances, and "le[ft] open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation." 547 U.S. at 288, n.18. North Carolina has adopted such a statutory scheme, which provides a reasonable method for ascertaining the State's medical reimbursements, [**16] while still protecting the interests of Medicaid

recipients, including the Plaintiffs in this matter. The Court agrees with the decision of the *Andrews* court that §§ 108-57 and 108A-59 are consistent with federal law, and consequently, the Court rejects Plaintiff's contention that the statutes are not controlling in this matter. *See Tristani v. Richman*, 609 F. Supp. 2d 423, 464-65 (W.D. Pa. 2009) (concluding that "[a] close reading of *Ahlborn* confirms the correctness of the reasoning employed by . . . [*659] the North Carolina Supreme Court"). Therefore, Defendant is entitled to summary judgment.

IV. Order

IT IS, THEREFORE, ORDERED that Plaintiff's Motion for Summary Judgment is hereby **DENIED**. Defendant's Motion for Summary Judgment is hereby **GRANTED**. Accordingly, Plaintiff's cause of action is dismissed with prejudice.

Signed: June 28, 2010

/s/ Richard L. Voorhees
Richard L. Voorhees
United States District Judge

OPINION OF THE SUPREME COURT OF NORTH CAROLINA, DECIDED DECEMBER 12, 2008

APPENDIX C

KATELYN ANDREWS, a minor, through her Guardian ad Litem, DAVID ANDREWS; and DAVID ANDREWS and ANDREA ANDREWS, individually

v.

VANESSA P. HAYGOOD, M.D., individually; CENTRAL CAROLINA OBSTETRICS AND GYNECOLOGY, P.A., a North Carolina Corporation; THE WOMEN'S HOSPITAL OF GREENSBORO, a North Carolina Not-for-Profit Corporation; KIM RICHEY, R.N., individually; and JENNIFER DALEY, R.N., individually,

v.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, Intervenor

No. 57A07-2
SUPREME COURT OF NORTH CAROLINA
362 N.C. 599, *; 669 S.E.2d 310, **;
2008 N.C. LEXIS 984, ***

October 13, 2008, Heard in the Supreme Court
December 12, 2008, Filed

SUBSEQUENT HISTORY: US Supreme Court certiorari denied by Brown v. NC Dep't of H&HS, 2009 U.S. LEXIS 4519 (U.S., June 15, 2009)

OPINION OF THE SUPREME COURT OF NORTH CAROLINA, DECIDED DECEMBER 12, 2008

PRIOR HISTORY: Andrews v. Haygood, 188 N.C. App. 244, 655 S.E.2d 440, 2008 N.C. App. LEXIS 91 (2008)

DISPOSITION: [***1] AFFIRMED; DISCRETIONARY REVIEW IMPROVIDENTLY ALLOWED IN PART.

COUNSEL: Wishart, Norris, Henninger & Pittman, P.A., by Pamela S. Duffy and Molly A. Orndorff, for trustee-appellant Charlie D. Brown.

Roy Cooper, Attorney General, by Susannah P. Holloway, Assistant Attorney General, for intervenor-appellee North Carolina Department of Health and Human Services, Division of Medical Assistance.

Glenn, Mills, Fisher & Mahoney, P.A., by Carlos E. Mahoney, Counsel for North Carolina Academy of Trial Lawyers, amicus curiae.

JUDGES: NEWBY, Justice. Justice HUDSON dissenting. Justices BRADY and TIMMONS-GOODSON join in this dissenting opinion.

OPINION BY: NEWBY

OPINION

[**311] [*600] Appeal pursuant to N.C.G.S. § 7A-30(2) from the decision of a divided panel of the Court of Appeals, 188 N.C. App. 244, 655 S.E.2d 440

(2008), affirming an order entered on 27 July 2006 by Judge Steve A. Balog in Superior Court, Alamance County. On 10 April 2008, the Supreme Court allowed appellant's petition for discretionary review of additional issues. Heard in the Supreme Court 13 October 2008.

NEWBY, Justice.

This case presents the question of whether the statutory framework governing the State's subrogation claim for medical expenses on a Medicaid recipient's tort claim [***2] settlement complies with federal Medicaid law as interpreted by the Supreme Court of the United States in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006). Because *Ahlborn* does not mandate a specific method for determining the medical expense portion of a plaintiff's settlement, we uphold North Carolina's reasonable statutory scheme and accordingly affirm the Court of Appeals.

Plaintiff Katelyn Andrews brought suit against defendants, alleging medical malpractice and seeking recovery for injuries she sustained at birth. The parties entered into confidential settlement agreements and established a settlement account for the proceeds. [*601] Because Katelyn is a North Carolina Medicaid recipient, the North Carolina Division of Medical Assistance ("DMA") sought to recover from the account the amount it paid for her medical expenses, $1,046,681.94. The trial court

determined the DMA has subrogation rights to the entire amount of the settlement, limited by the statutory provision that only one-third of a recovery is subject to subrogation. N.C.G.S. § 108A-57(a) (2005). Because the amount expended by the DMA was less than one-third [***3] of the settlement, the trial court ordered full reimbursement. [**312] The trustee of the settlement account appealed.

The Court of Appeals affirmed the trial court's order based on our prior decision in *Ezell v. Grace Hospital, Inc.*, 360 N.C. 529, 631 S.E.2d 131 (2006), *rev'g per curiam for reasons stated in the dissenting opinion*, 175 N.C. App. 56, 623 S.E.2d 79 (2005), *reh'g denied*, 361 N.C. 180, 641 S.E.2d 4 (2006). *Andrews v. Haygood*, 188 N.C. App. 244, 250, 655 S.E.2d 440, 444 (2008). However, a dissent questioned the majority's reliance on *Ezell* because in reversing the Court of Appeals, we did not specifically address the applicability of the holding in *Ahlborn* to the issues in *Ezell*. *Id.* at 251-53, 655 S.E.2d at 444-45 (Wynn, J., dissenting).

Based on the dissent, the trustee appealed to this Court, and we granted review of additional issues arising from the trial court's denial of requests for an evidentiary allocation hearing and for a delay in resolution of the case until a third party could be joined. The trustee contends that absent an agreement between the parties, federal law requires a judicial determination of the portion of a tort claim settlement that represents the recovery [***4] of medical

expenses. In response, the DMA contends the statutory one-third limiting provision complies with *Ahlborn*'s interpretation of federal Medicaid law. The DMA thus argues that judicial apportionment of medical expenses from the settlement is not required. We agree.

Medicaid is a cooperative program that provides federal and state medical care funding for certain individuals who are unable to afford their own medical costs. *See Ahlborn*, 547 U.S. at 275, 126 S. Ct. at 1758, 164 L. Ed. 2d at 468. Participating states are required by federal law to "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan" and to "seek reimbursement for [medical] assistance [made available on behalf of a recipient] to the extent of such legal liability." 42 U.S.C. § 1396a(a)(25)(A)-(B) (2000). State laws control the administration of the program, including the method by which a state may seek reimbursement for prior Medicaid assistance. *See Ahlborn*, 547 U.S. at [*602] 275-77, 126 S. Ct. at 1758-59, 164 L. Ed. 2d at 468-70. State laws, however, must comply with federal Medicaid law. *Id.*

The Supreme Court of the United States [***5] addressed the operation of a state's Medicaid reimbursement statute in *Ahlborn*, in which the Court was asked to determine whether the Arkansas Department of Health and Human Services ("ADHS") could claim a statutory lien on a settlement for more than the portion that by stipulation represented the

recovery of medical expenses. *Ahlborn*, 547 U.S. at 279-80, 126 S. Ct. at 1760-61, 164 L. Ed. 2d at 470-71. The Arkansas statutes in question[1] allowed total reimbursement to ADHS for all previous medical payments made on the plaintiff's behalf. *Id.* at 278-79, 126 S. Ct. at 1759-60, 164 L. Ed. 2d at 470-71. *Ahlborn*, a Medicaid recipient, challenged the statute because it permitted reimbursement from settlement proceeds recovered for damages other than medical expenses. *Id.* at 274, 126 S. Ct. at 1757-58, 164 L. Ed. 2d at 468. In her suit against the alleged tortfeasors,

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[1] The pertinent sections of the Arkansas Code read:

> As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services *to the full extent* of any amount which may be paid by Medicaid for the benefit of the applicant.

Ark. Code. Ann. § 20-77-307(a) (2001) (emphasis added). Accordingly, "when medical assistance benefits are provided . . . to a . . . recipient because of injury, disease, or disability for which another person is liable . . . the Department of Human Services shall have a right to recover from the person *the cost of benefits so provided*." *Id.* § 20-77-301(a) (2001) (emphasis added).

she sought compensation for medical expenses, pain and suffering, lost wages, and permanent impairment of her future wage-earning ability. *Id.* at 273, 126 S. Ct. at 1757, 164 L. Ed. 2d at 467. After the parties settled for $550,000, ADHS asserted a lien against the settlement for $215,645.30--the total amount of prior payments [***6] made by ADHS for Ahlborn's medical care. *Id.* at 274, 126 S. Ct. at 1757, 164 L. Ed. 2d at 468. Ahlborn challenged the lien, alleging it violated federal Medicaid law "insofar as its satisfaction would require depletion of compensation for [**313] injuries other than past medical expenses." *Id.*

Before trial, Ahlborn and ADHS stipulated to several facts. *Id.* at 274, 126 S. Ct. at 1757-58, 164 L. Ed. 2d at 468. The reasonable value of Ahlborn's claim, absent [***7] any consideration of liability, was specified to be approximately $3,040,708.18. *Id.* The parties agreed the settlement amount of $550,000 represented approximately one-sixth of the estimated total damages. *Id.* ADHS further stipulated that if Ahlborn's construction of the Arkansas statute were correct, ADHS [*603] would only be entitled to reimbursement for one-sixth of the total past medical payments, or $35,581.47. *Id.*

The Supreme Court of the United States determined that ADHS was entitled to recover $ 35,581.47, the portion of the settlement stipulated to represent Ahlborn's recovery of medical expenses. *Id.* at 292, 126 S. Ct. at 1767, 164 L. Ed. 2d at 479. The Court held: "Federal Medicaid law does not authorize

ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47 . . . . Arkansas' third-party liability provisions are unenforceable insofar as they compel a different conclusion." *Id.* *Ahlborn* thus controls when there has been a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement. In those cases, the State may not receive reimbursement in excess of the portion so designated.

The *Ahlborn* holding, limited by the parties' [***8] stipulations, did not require a specific method for determining the portion of a settlement that represents the recovery of medical expenses. *See id.* at 288, 126 S. Ct. at 1765, 164 L. Ed. 2d at 476. The Court recognized that "some States have adopted special rules and procedures for allocating tort settlements" under certain circumstances, but ultimately "express[ed] no view on the matter" and "le[ft] open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation." *Id.* at 288 n.18, 126 S. Ct. at 1765 n.18, 164 L. Ed. 2d at 476 n.18. *Ahlborn* thus does not mandate a judicial determination of the portion of a settlement from which the State may be reimbursed for prior medical expenditures. Instead, the Supreme Court left to the States the decision on the measures to employ in the operation of their Medicaid programs. *Id.*

Our General Assembly created a statutory method to determine the amount of the State's reim-

bursements for prior medical payments. North Carolina law provides that Medicaid recipients are "deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise to which [the recipient] [***9] may be entitled." N.C.G.S. § 108A-59(a) (2005). Implementation of the recipient's statutory assignment is governed by section 108A-57(a) of our General Statutes:

> Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State . . . shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance . . . against any person. . . . Any attorney retained by the beneficiary of the assistance shall, out of [*604] the proceeds obtained on behalf of the beneficiary by settlement with . . . a third party . . . distribute to the Department the amount of assistance paid by the Department . . . *but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.*

Id. § 108A-57(a) (2005) (emphasis added). While encouraging complete recovery for past medical payments, the North Carolina statute allows total reimbursement to the State only when "the amount of assistance" previously paid for medical expenses is one-third of the plaintiff's settlement or less. *Id.* If the amount of the State's claim exceeds one-third of the

recovery, our statute limits reimbursement to one-third of the settlement. [***10] *Id.* Section 108A-57(a) thus prevents excessive depletion of a plaintiff's recovery to satisfy the State's reimbursement lien. Nonetheless, plaintiffs are free to negotiate a settlement with the State for a lien amount less than that required by our statutes.

Rather than requiring a specific determination of the medical expense portion of a settlement, North Carolina employs an alternative statutory procedure that we believe is permitted by *Ahlborn*. *See Ahlborn*, 547 U.S. at 288 n.18, 126 S. Ct. at 1765 n.18, 164 [**314] L. Ed. 2d at 476 n.18. Our state law defines "the portion of the settlement that represents payment for medical expenses" as the lesser of the State's past medical expenditures or one-third of the plaintiff's total recovery, limiting the State's reimbursement to the portion so designated. *See* N.C.G.S. § 108A-57(a); *see also Ahlborn*, 547 U.S. at 282, 126 S. Ct. at 1762, 164 L. Ed. 2d at 472-73. The one-third limitation of section 108A-57(a) thus comports with *Ahlborn* by providing a reasonable method for determining the State's medical reimbursements, which it is required to seek in accordance with federal Medicaid law. *See* 42 U.S.C. § 1396a(a)(25)(A)-(B) (2000).

This statutory scheme [***11] protects plaintiffs' interests while promoting efficiency in Medicaid reimbursement cases throughout North Carolina. In enacting our statute, the General Assembly may have considered factors such as the strain on resources to

send State employees across North Carolina to participate in evidentiary allocation hearings each time a Medicaid recipient recovers from a third party. Likewise, the legislature may have found it important that a case-by-case determination of the medical expense portion of settlements could lead to variable results and increased litigation due to inconsistency in outcomes. Certainly, "[w]eighing these and other public policy considerations is the province of our General Assembly, [*605] not this Court." *Shaw v. U.S. Airways, Inc.*, 362 N.C. 457, 463, 665 S.E.2d 449, 453 (2008).

We accord a presumption of validity to the General Statutes of this State. *See, e.g., Wayne Cty. Citizens Ass'n for Better Tax Control v. Wayne Cty. Bd. of Comm'rs*, 328 N.C. 24, 29, 399 S.E.2d 311, 314-15 (1991); *Ramsey v. N.C. Veterans Comm'n*, 261 N.C. 645, 647, 135 S.E.2d 659, 661 (1964). When the General Assembly enacts a statute after examining its legal and public policy implications, it is [***12] not the province of this Court to substitute its judgment for that of our legislature. *See, e.g., Shaw*, 362 N.C. at 463, 665 S.E.2d at 453; *Newlin v. Gill*, 293 N.C. 348, 350-52, 237 S.E.2d 819, 821-22 (1977); *see also Bockweg v. Anderson*, 328 N.C. 436, 451-52, 402 S.E.2d 627, 636-37 (1991) (Martin, J., dissenting). As we previously did in *Ezell*, we have again reviewed section 108A-57(a) and find it to be a reasonable framework that comports with the requirements of federal Medicaid law as interpreted by *Ahlborn*. If the General

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Assembly desires a different result in these cases it may amend the statutes accordingly.

We therefore affirm the Court of Appeals' holding that the trial court did not err in subrogating the plaintiff's settlement proceeds to the DMA, subject to the one-third statutory limitation. Because our resolution of this issue is dispositive, we need not address the requested joinder of United Healthcare and the Court of Appeals decision as to that issue remains undisturbed.

AFFIRMED; DISCRETIONARY REVIEW IMPROVIDENTLY ALLOWED IN PART.

DISSENT BY: HUDSON

DISSENT

Justice HUDSON dissenting.

Although I agree with the majority that "[*Arkansas Department of Health & Human Services v.] Ahlborn* does [***13] not mandate a specific method for determining the medical expense portion of a plaintiff's settlement," the United States Supreme Court nevertheless did explicitly hold in *Ahlborn* that a State may not violate the anti-lien provisions of 42 U.S.C. §§ 1396a(a)(18) and 1396p by requiring a Medicaid recipient to reimburse it out of settlement funds designated for purposes other than medical care. 547 U.S. 268, 284-85, 126 S. Ct. 1752, 164 L. Ed. 2d 459, 474 (2006). The terms of the settlement at issue here

provide insufficient detail to allow us to determine whether the application of N.C.G.S. § 108A-57(a) would violate the anti-lien provisions of the federal Medicaid statutes, pursuant to the holding in *Ahlborn*. [*606] Because I conclude that we are bound to follow *Ahlborn*, I must respectfully dissent.

As observed by the United States Supreme Court, the federally funded and administered Medicaid program is "a cooperative one," with participating states "compl[ying] with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program" in exchange for the federal funding. *Id.* at 275, 164 [**315] L. Ed. 2d at 468-69. Among these requirements is "that [***14] the state agency in charge of Medicaid . . . 'take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan.'" *Id.* at 275, 164 L. Ed. 2d at 469 (quoting 42 U.S.C. § 1396a(a)(25)(A) (2000) (alteration in original)). Further,

> The [state] agency's obligation extends beyond mere identification, however; "in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local

> agency will seek reimbursement for such assistance to the extent of such legal liability."

Id. at 276, 164 L. Ed. 2d at 469 (quoting 42 U.S.C. § 1396a(a)(25)(B)). The federal Medicaid statutes obligate participating states to enact so-called "assignment laws" to provide for such reimbursement. *Id.* at 276-77, 164 L. Ed. 2d at 469-70 (citing 42 U.S.C. §§ 1396a(a)(25)(H), 1396k(a)).

In enacting section 108A-57(a), our General Assembly fulfilled this requirement while also explicitly limiting the percentage of a settlement that the State could recover [***15] through assignment:

> Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, *shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance*, or of the beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person. The county attorney, or an attorney retained by the county or the State or both, or an attorney retained by the beneficiary of the assistance if this attorney has actual notice of payments made under this Part shall enforce this section. Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary

> by settlement [*607] with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, *but the amount paid to the Department shall not exceed one-third of the gross amount* [***16] *obtained or recovered.*

N.C.G.S. § 108A-57(a) (2005) (emphases added). Moreover, the General Assembly specifically provided that "the provisions of this Part shall be liberally construed in relation to [the federal Social Security Act providing grants to the states for medical assistance] so that the intent to comply with it shall be made effectual." *Id.* § 108A-56 (2005). In my view, the majority's interpretation runs contrary to this directive by risking violations of the federal anti-lien provisions, which would render our State out of compliance with Medicaid requirements and thereby jeopardize the funding our State receives.

The General Assembly's explicit direction that we defer to the federal provisions as necessary guides our consideration of the interaction of these federal and state statutes. In addition, because this case involves questions of federal statutory law, we are bound by the United States Supreme Court's interpretation of the federal Medicaid statutes. As this Court has stated:

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> It is elementary that an act of Congress, in pursuance of the Constitution of the United States, is the supreme law of the land. Constitution of the United States, Article VI, Clause 2. Thus, [***17] in case of a conflict between such an act and the law of North Carolina, the act of Congress controls and, so long as it remains in effect, modifies the law of this State and the authority of its courts to render judgment in accordance therewith. It is equally well settled that a decision of the Supreme Court of the United States, construing an act of Congress, is conclusive and binding upon this Court.

R.H. Bouligny, Inc. v. United Steelworkers, 270 N.C. 160, 173-74, 154 S.E.2d 344, 356 (1967). The United States Supreme Court [**316] decision in *Ahlborn* directly addresses and determines the question presented by this case, as our state statute is similar to the one at issue in *Ahlborn* and the factual situations are analogous. Therefore, I conclude that *Ahlborn* is binding upon this Court, and its reasoning and holding compel the conclusion that the application of N.C.G.S. § 108A-57(a) [*608] here, without any further determination of how the settlement proceeds were allocated among the different types of damages alleged by plaintiff, would be contrary to federal law.

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In delivering the opinion of a unanimous Court in *Ahlborn*, Justice John Paul Stevens framed the issue as follows:

> When a Medicaid recipient [***18] in Arkansas obtains a tort settlement following payment of medical costs on her behalf by Medicaid, Arkansas law automatically imposes a lien on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs--like pain and suffering, lost wages, and loss of future earnings. The Court of Appeals for the Eight Circuit held that this statutory lien contravened federal law and was therefore unenforceable. Other courts have upheld similar lien provisions. We granted certiorari to resolve the conflict and now affirm.

547 U.S. at 272, 164 L. Ed. 2d at 467 (internal citations omitted). Thus, contrary to the majority's assertion that the *Ahlborn* holding controls only in situations in which there has been "a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement," the Supreme Court in no way rested its analysis on whether a settlement had been so allocated.

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Rather, the Supreme Court in *Ahlborn* "express[ed] no view on" how such allocation [***19] should be determined "[e]ven in the absence of such a postsettlement agreement," *id.* at 547 at 288 & n.18, 164 L. Ed. 2d at 476 & n.18, emphasizing instead simply that, regardless of how an allocation is made, "the exception carved out by [the anti-lien provisions laid out in 42 U.S.C. §§ 1396a(a)(18) and 1396p] is limited to payments [by the third party to the plaintiff-beneficiary] for medical care. Beyond that, the anti-lien provision applies," *id.* at 284-85, 164 L. Ed. 2d at 474. Indeed, the Court repeatedly emphasized this point as to "whether [a state agency] can lay claim to more than the portion of [the plaintiff-beneficiary's] settlement that represents medical expenses":

> The text of the federal third-party liability provisions suggests not; it focuses on recovery of payments for medical care. Medicaid recipients must, as a condition of eligibility, "assign the [*609] State any rights . . . *to payment for medical care* from any third party," 42 U.S.C. § 1396k(a)(1)(A) (emphasis added), not rights to payment for, for example, lost wages.

Id. at 280, 164 L. Ed. 2d at 471 (alteration in original). More explicitly, "under the federal statute the State's assigned rights extend only to recovery [***20] of payments for medical care." *Id.* at 282, 164 L. Ed. 2d at 472. Likewise, "assignment of the right to compensation for lost wages and other nonmedical

damages is nowhere authorized by the federal third-party liability provisions." *Id.* at 286 n.16, 164 L. Ed. 2d at 475 n.16.

These statements broadly prohibit a state's claim to reimbursement from any funds not earmarked solely for medical expenses under any circumstances. Accordingly, to the extent that the terms of a settlement are unclear as to the portion designated for medical expenses, the *Ahlborn* analysis requires states to fashion a method to make those determinations and protect their right to reimbursement, for example, "by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Id.* at 288, 164 L. Ed. 2d at 476. Simply put, an indispensable step in calculating the amount of a State's right to reimbursement for medical expenses is establishing how much of a third-party settlement has been allocated to the medical expenses of the plaintiff-beneficiary.

[**317] The majority would hold that in N.C.G.S. § 108A-57(a), the General Assembly attempted to do just that and that [***21] the statute "comports with *Ahlborn* by providing a reasonable method for determining the State's medical reimbursements," namely, capping the reimbursement at no more than one-third of a beneficiary's settlement with a third party. However, application of the bright-line rule articulated by the majority in a case like this one, in which there has been no allocation, could allow precisely the result that is explicitly barred by

Ahlborn. In fact, this would be the outcome with any settlement in which the amount actually paid by the Division of Medical Assistance (DMA) is greater than the amount of the settlement designated for medical expenses, but less than the one-third cap specified in N.C.G.S. § 108A-57(a).

A hypothetical example illustrates this point.[2] Suppose a plaintiff--a past beneficiary of Medicaid assistance--settles with a tortfeasor [*610] for $2 million following an automobile accident. She initially alleged damages totaling $5 million, including $500,000 in past medical expenses, $1 million in future medical expenses, $1.5 million in pain and suffering, and $2 million in lost future earnings income. Medicaid, through DMA, paid the full $500,000 in actual past medical costs [***22] for the beneficiary's treatment following the accident. Under the majority's holding and application of N.C.G.S. § 108A-57(a), DMA would be entitled to $500,000 of the settlement. However, without knowing more about how the parties allocated the settlement among the different types of damages sought, the amounts might suggest that the parties, as in *Ahlborn*, reached a settlement that prorated the beneficiary's damages, awarding her forty percent of what she sought in each category of damages. In that scenario, of the $2 million

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[2] Because the settlement agreements here are confidential and held under seal, I use only hypothetical figures.

settlement, $200,000 would be designated for past medical expenses, $400,000 for future medical expenses, $600,000 for pain and suffering, and $800,000 for lost future earnings income. Awarding the full $500,000 to DMA would thus exceed the $200,000 designated for past medical expenses and clearly violate the explicit holding of *Ahlborn*.

Likewise, N.C.G.S. § 108A-57(a) and the majority opinion make no distinction between past medical expenses paid by DMA that relate directly to the injury that is the basis of the settlement and expenses that were [***23] paid for treatment of a preexisting, ongoing condition. For example, in the scenario outlined above, suppose DMA had paid $500,000 in medical costs for the beneficiary, but only $300,000 of that amount related to the automobile accident, with the balance of $200,000 spent on treatment for the beneficiary's leukemia. Under the majority's holding, DMA could still claim the full $500,000 from the beneficiary, as that amount does not exceed the one-third statutory limitation in N.C.G.S. § 108A-57(a)--even though that recovery would include reimbursement for medical expenses totally unrelated to the accident or the settlement. This result, permitted by this Court's earlier holding in *Ezell v. Grace Hospital, Inc.*, 360 N.C. 529, 631 S.E.2d 131, *rev'g per curiam for reasons stated in the dissent* 175 N.C. App. 56, 623 S.E.2d 79 (2005), *reh'g denied*, 361 N.C. 180, 641 S.E.2d 4 (2006), would clearly violate the anti-lien provisions of the federal Medicaid

statutes, contrary to the holding of *Ahlborn*. As such, I also believe we should overrule that decision.

Here, as in *Ahlborn*, plaintiff's civil suit sought damages including, but not limited to, past medical expenses paid by Medicaid and [***24] others; the complaint also alleged damages for mental and physical pain and anguish, severe and permanent injury, future medical expenses, [*611] loss of future earnings, disfigurement and loss of normal use of her body, her parents' expenses for education and life care, and her parents' emotional distress and derivative claims. These claims were settled among all parties, with proceeds held in a single account and no allocations made as to which specific amounts represented damages for which particular type of claim. Nevertheless, the parties clearly intended the settlement to account for all of the different [**318] types of damages alleged not just by plaintiff, but also by her parents. The parties concede that the amount of the settlement here allows DMA to be fully reimbursed for the entire $1,046,681.94 it had paid through October 2005 for plaintiff's medical care, without violating the one-third cap of N.C.G.S. § 108A-57(a). However, the lack of stipulation or other determination as to the allocation of the settlement funds among the damages leaves us unable to conclude whether a DMA lien for full reimbursement would impermissibly entitle DMA to an amount greater than the medical expenses [***25] portion of the settlement, as is prohibited by *Ahlborn*.

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In addition, the majority misinterprets N.C.G.S. § 108A-57(a) as being the General Assembly's blanket determination that the full one-third of any settlement amount between a plaintiff and a third party is for medical expenses.[3] In my view, that is neither what

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[3] Although neither party has raised the issue on unconstitutional impairment of contract before this Court, I also believe the majority's interpretation could lead to the conclusion that N.C.G.S. § 108A-57(a) violates the Contract Clause of the United States Constitution by overriding the intentions of parties to private contract. *See* U.S. Const. Art. I, § 10, cl. 1 ("No state shall . . . pass any . . . law impairing the obligations of contracts . . ."), *Adair v. Orrell's Mut. Burial Ass'n*, 284 N.C. 534, 538, 201 S.E.2d 905, 908 ("Any law which enlarges, abridges or changes the intention of the parties as indicated by the provisions of a contract necessarily impairs [***27] the contract . . . .") (citations omitted), *appeal dismissed*, 417 U.S. 927, 41 L. Ed. 2d 231 (1974).

I recognize that such impairment is sometimes permissible "to protect the general welfare of its citizens, so long as such impairment is reasonable and necessary to serve an important public purpose." *Bailey v. State*, 348 N.C. 130, 151, 500 S.E.2d 54, 66 (1998) (citing *U.S. Trust Co. of N.Y. v. New Jersey*, 431 U.S. 1, 25-26, 52 L. Ed. 2d 92, 111-12 (1977)). However, "'a State is not free to impose a drastic impairment when an evident and more moderate

the statute says nor what it does. According to the plain language of the statute, the legislature envisioned both that a beneficiary could have a private attorney representing her in an action against a third party, see N.C.G.S. § 108A-57(a) (referring to "[a]ny attorney retained by the [*612] beneficiary of the assistance"), and that for most settlements, damages for medical expenses would be prorated among the various providers, *see id.* (requiring the recipient's attorney to "distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered"). Thus, the General Assembly itself recognized that either stipulations by the parties or evidentiary hearings would be necessary to determine the amount of [***26] recovery by DMA and others seeking reimbursement for payment of medical expenses. Moreover, as with other lien statutes, *see, e.g.*, N.C.G.S. § 97-10.2(f)

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course would serve its purposes equally well.'" *Id.* at 152, 500 S.E.2d at 67 (quoting *U.S. Trust*, 431 U.S. at 31, 52 L. Ed. 2d at 115). Moreover, "'[i]n applying this standard, . . . complete deference to a legislative assessment of reasonableness and necessity is not appropriate because the State's self-interest is at stake.'" *Id.* at 151, 500 S.E.2d at 66 (quoting *U.S. Trust*, 431 U.S. at 25-26, 52 L. Ed. 2d at 112 (alteration in original)).

(2005) (Workers' Compensation Act), the General Assembly acknowledged that the beneficiary's attorney would likely be entitled to a large percentage of the settlement as a contingent fee; as such, the one-third cap represents a reasonable ceiling on the amount paid to DMA while also ensuring that the beneficiary would still recover a meaningful proportion of the settlement.

This reading of the statute is supported by the public policy rationale that underpins the federal requirements for "assignment laws" adopted by the states to seek reimbursement for the Medicaid payments [***28] they make. Such assignments prevent "double recovery" by a beneficiary: because the beneficiary is required to repay Medicaid from the medical expenses portion of his settlement with a third-party tortfeasor, he does not keep both the State's money and damages recovered from the tortfeasor. However, both the federal and state statutory schemes rely on the beneficiary--not the State or county--to bring a civil action against the third-party tortfeasor. Indeed, without the beneficiary's action to bring the suit, the State may enjoy no recovery at all for the Medicaid payments it made to the beneficiary as a result of the injury or accident. Thus, the State seeks to [**319] encourage beneficiaries to bring such suits. Accordingly, the statute is designed to protect the State's interest in having the suit brought by providing an incentive for the beneficiary to bring the suit--namely, by safeguarding some portion of the settlement for the beneficiary rather than allowing all of the proceeds to

be paid to the attorneys and to DMA and other medical lienholders. Without this guarantee of some return, beneficiaries would be unlikely to go through the time and inconvenience associated with pursuing [***29] a civil action, and the State or DMA would be left with no recovery at all.

Application of N.C.G.S. § 108A-57(a) in a manner consistent with this rationale likewise comports with the reasoning relied upon by [*613] the United States Supreme Court in *Ahlborn* to ensure that a state Medicaid agency does not "force an assignment of, or place a lien on, any other portion of [the beneficiary's] property" or settlement proceeds designated to compensate a beneficiary for other types of damages. 547 U.S. at 284, 164 L. Ed. 2d at 474. Specifically, *Ahlborn* compels our State to apply N.C.G.S. § 108A-57(a) in compliance with the following language:

> Federal Medicaid law does not authorize [the state agency] to assert a lien on [a beneficiary's] settlement in an amount exceeding [the pro rata portion designated as reimbursement for medical payments made], and the federal anti-lien provision affirmatively prohibits it from doing so. [The State's] third-party liability provisions are unenforceable insofar as they compel a different conclusion.

Id. at 292, 164 L. Ed. 2d at 479. Thus, I would not find that N.C.G.S. § 108A-57(a) violates the federal anti-lien provisions on its face, as it could be applied to factual [***30] situations in which the parties have stipulated, or an evidentiary hearing has determined, how to allocate the settlement proceeds among medical expenses and other damages. Nevertheless, I conclude that here, when the settlement proceeds have not been so allocated, the only way to ensure that the application of the statute complies with *Ahlborn* is to provide for such an allocation.[4]

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[4] As noted by the Supreme Court in *Ahlborn*, the risk of settlement manipulation, also discussed by Judge Steelman in his dissent in *Ezell*, 175 N.C. App. at 65-66, 623 S.E.2d at 85, "can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Ahlborn*, 547 U.S. at 288, 164 L. Ed. 2d at 476. In addition, the United States Supreme Court disavowed this rationale--that was the basis of Judge Steelman's dissent, which we adopted, 360 N.C. 529, 631 S.E.2d 131--and observed that "there [is] a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others." *Ahlborn*, 547 U.S. at 288, 164 L. Ed. 2d at 476. For this reason too I would disagree [***31] with the majority opinion's conclusion that *Ezell* is still good law.

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I would therefore reverse the Court of Appeals with instructions to remand to the trial court to hold an evidentiary hearing to ensure that the DMA lien is not applied to settlement proceeds aside from those designated to reimburse medical expenses.

Justices BRADY and TIMMONS-GOODSON join in this dissenting opinion.

N.C. GEN. STAT. § 108A-57 (2011)

APPENDIX D

CHAPTER 108A. SOCIAL SERVICES
ARTICLE 2. PROGRAMS OF PUBLIC ASSISTANCE
PART 6. MEDICAL ASSISTANCE PROGRAM

N.C. Gen. Stat. § 108A-57 (2011)

§ 108A-57. Subrogation rights; withholding of information a misdemeanor.

(a) Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance, or of the beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person. The county attorney, or an attorney retained by the county or the State or both, or an attorney retained by the beneficiary of the assistance if this attorney has actual notice of payments made under this Part shall enforce this section. Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or

recovered, but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.

The United States and the State of North Carolina shall be entitled to shares in each net recovery under this section. Their shares shall be promptly paid under this section and their proportionate parts of such sum shall be determined in accordance with the matching formulas in use during the period for which assistance was paid to the recipient.

(b) It is a Class 1 misdemeanor for any person seeking or having obtained assistance under this Part for himself or another to willfully fail to disclose to the county department of social services or its attorney the identity of any person or organization against whom the recipient of assistance has a right of recovery, contractual or otherwise.

(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article.

HISTORY: 1973, c. 476, s. 138; c. 1031, s. 1; 1979, 2nd Sess., c. 1312, ss. 1, 2; 1981, c. 275, s. 1; 1987 (Reg. Sess., 1988), c. 1022; 1993, c. 539, s. 815; 1994, Ex. Sess., c. 24, s. 14(c); 1996, 2nd Ex. Sess., c. 18, s. 24.2(a); 2009-16, s. 4(c).

N.C. GEN. STAT. § 108A-59 (2011)

APPENDIX E

CHAPTER 108A. SOCIAL SERVICES
ARTICLE 2. PROGRAMS OF PUBLIC ASSISTANCE

PART 6. MEDICAL ASSISTANCE PROGRAM

N.C. Gen. Stat. § 108A-59 (2011)

§ 108A-59. Acceptance of medical assistance constitutes assignment to the State of right to third party benefits; recovery procedure

(a) Notwithstanding any other provisions of the law, by accepting medical assistance, the recipient shall be deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise, to which he may be entitled.

It shall be the responsibility of the county attorney of the county from which the medical assistance benefits are received or an attorney retained by that county and/or the State to enforce this subsection, and said attorney shall be compensated for his services in accordance with the attorneys' fee arrangements approved by the Department of Health and Human Services.

(b) The responsible State agency will establish a third party resources collection unit that is adequate to assure maximum collection of third party resources.

(c) Notwithstanding any other law to the contrary, in all actions brought pursuant to subsection (a) of this section to obtain reimbursement for payments for

N.C. GEN. STAT. § 108A-59 (2011)

medical services, liability shall be determined on the basis of the same laws and standards, including bases for liability and applicable defenses, as would be applicable if the action were brought by the individual on whose behalf the medical services were rendered.

HISTORY: 1977, c. 664; 1979, 2nd Sess., c. 1312, ss. 3-5; 1981, c. 275, s. 1; 1995, c. 508, s. 2; 1997-443, s. 11A.118(a).

42 U.S.C. § 1396a(a)(18) (2006)

APPENDIX F

TITLE 42. THE PUBLIC HEALTH AND WELFARE

CHAPTER 7. SOCIAL SECURITY ACT
TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

42 U.S.C. § 1396a(a)(18) (2006)

§ 1396a. State plans for medical assistance

(a) Contents.

A State plan for medical assistance must--

****

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid,[,] transfers of assets, and treatment of certain trusts;

****

42 U.S.C. § 1396a(a)(25)(H) (2006)

APPENDIX G

TITLE 42. THE PUBLIC HEALTH AND WELFARE

CHAPTER 7. SOCIAL SECURITY ACT
TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

42 U.S.C. § 1396a(a)(25)(H) (2006)

§ 1396a. State plans for medical assistance

(a) Contents.

A State plan for medical assistance must--

****

(25) provide--

****

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

****

42 U.S.C. § 1396k (2006)

APPENDIX H

TITLE 42. THE PUBLIC HEALTH AND WELFARE

CHAPTER 7. SOCIAL SECURITY ACT
TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

42 U.S.C. § 1396k (2006)

§ 1396k. Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall--

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required--

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this title [42 USC §§ 1396 et seq.] and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in

42 U.S.C. § 1396k (2006)

subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1396a(l)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

42 U.S.C. § 1396k (2006)

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396p(a)(1) (2006)

APPENDIX I

TITLE 42. THE PUBLIC HEALTH AND WELFARE

CHAPTER 7. SOCIAL SECURITY ACT
TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

42 U.S.C. § 1396p(a)(1) (2006)

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan.

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan.

****

CENTERS FOR MEDICARE & MEDICAID SERVICES
GUIDANCE MEMO, July 3, 2006

APPENDIX J

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850 [LOGO OMITED]

Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group
(DEHPG)

July 3, 2006

TO: All Associate Regional Administrators for Medicaid and State Operations

FROM: Gale Arden /S/
Director

RE: State Options for Recovery Against Liability Settlements In Light of U. S. Supreme Court Decision in *Arkansas Department of Human Services v. Ahlborn*

The purpose of this memorandum is to clarify third party recovery rules and options for States in the context of the U. S. Supreme Court's decision in *Arkansas Department of Human Services v. Ahlborn* ("*Ahlborn*"). The Court ruled against the State in this case, in which the federal government had filed an *amicus* brief, holding that the federal assignment and lien provisions prohibited full recovery of the State's payments for Medicaid if the State's recovery claim

exceeded the amount designated as compensation for medical items and services. States must comply with the decision in *Ahlborn*. However, States may be able to mitigate the adverse impact of the case by taking some of the actions discussed in this Memorandum. The Centers for Medicare. & Medicaid Services (CMS) strongly encourages States to consider implementing mitigating strategies, and we ask that you share the information in this memorandum with the States in your region.

Background:

On May 1, 2006 the United States Supreme Court, in a unanimous decision, held that the federal Medicaid statute only permits a State to recover its payments for medical assistance from the portion of a liability settlement attributable to medical items and services. The Court further held that if the State attempted to recover from more than the portion of a settlement that the parties allocated to medical items and services, it was in violation of the federal anti-lien statute. The federal government had filed an *amicus* brief in this case on behalf of the State of Arkansas.

The case concerned a Medicaid recipient who subsequently received a tort liability settlement of $550,000. The settlement was not apportioned between medical services, loss of earnings or pain and suffering claims. Arkansas asserted a lien in the amount of $215,645 against the entire settlement amount. Ahlborn argued that Arkansas could recover only that

portion of the settlement proceeds that Ahlborn determined was payment for medical expenses, as opposed to the much larger payment for lost wages or pain and suffering. Ahlborn based her argument on the federal anti-lien provision that prohibits imposition of a lien against the property of any individual on account of medical assistance paid or to be paid on his or her behalf under a State plan. Arkansas contended that the anti-lien provision did not prevent full recovery because, as a condition of Medicaid eligibility, Ahlborn had assigned to the State her right to any settlement, judgment or award paid by a third party liable for her medical costs resulting from the accident. The State argued that those settlement proceeds remained the property of the third party tortfeasor until the Medicaid program was fully reimbursed for the funds it expended on respondent's medical care. During the course of this litigation, in order to pave the way for summary judgment, Arkansas and Ahlborn entered into a stipulation which indicated that if Ahlborn's view of the case was correct, the amount of her settlement allocated to medical expenses would be only $35,581 or approximately 16% of its total recovery claim.

The Supreme Court held that the federal assignment provision, Section 1912(a)(1)(A) of the Social Security Act (the "Act"), provides only a limited assignment from the Medicaid recipient to the State for payment for medical items and services from a liable third party. Likewise, the Supreme Court held that the statutory provisions authorizing States to recover

prohibit the States from seeking anything greater than the limit of the tortfeasor's legal liability. See Section 1902(a)(25)(H) of the Act. The Court found that the limited assignment to the State prohibited full recovery, under Section 1902(a)(25)(H), of the State's payments for medical assistance if the State's recovery claim exceeded the amount attributed to compensation for medical items and services. Finally, to the extent the Arkansas State statute provided for filing a lien for full recovery of medical assistance payments, the Court found it conflicted with the Medicaid laws anti-lien provision, Section 1917(a)(1) of the Act, which prohibits the State from imposing liens against any individual prior to his death on account of medical assistance paid on his/her behalf.

What this means for Medicaid third party liability recovery programs:

Prior to the Supreme Court's decision in *Ahlborn*, CMS had interpreted the Medicaid third party liability provisions to authorize States to pass laws permitting full recovery of Medicaid assistance payments from third party liability settlements, regardless of how the parties allocated the settlement. The Supreme Court rejected this interpretation of the Medicaid statute and held that to the extent State laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws.

CENTERS FOR MEDICARE & MEDICAID SERVICES GUIDANCE MEMO, July 3, 2006

However, the Supreme Court also strongly noted that the States should become involved in the underlying tort litigation in order to influence the amount that is allocated in a settlement to medical items and services. Thus, the Supreme Court determined that a State's recovery rights could be protected, and the adverse consequences of the decision mitigated, by vigorous action on the part of a State to increase the amount of a settlement allocated to medical items and services. Absent such involvement, the Supreme Court found little sympathy in the State's argument that they should be able to recover from the total settlement.

While the federal government is reviewing its legislative options, it is imperative that States comply with the decision in *Ahlborn*. To assist States in determining how to proceed under the federal Medicaid third party liability recovery rules post-*Ahlborn* we provide the following:

State Actions Prohibited Under *Ahlborn*:

- The Court interpreted current federal Medicaid law to preclude the State from enforcing laws which broaden the assigned rights of a Medicaid recipient. States may only require assignment of the right to payment from a third party for healthcare (or medical) items and services.

    - The Court interpreted current federal Medicaid law to preclude the State from enforcing laws

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GUIDANCE MEMO, July 3, 2006

which broaden the recovery rights, *vis a vis* Medicaid beneficiaries, of the State Medicaid agency. A State may only recover from the amount of a third party payment to a Medicaid recipient that is allocated to healthcare (medical) items and services. **However, note that State tort or insurance liability provisions are a matter of State law and could be utilized to mitigate the adverse affects of the decision.** For example, a State can enact laws which provide for a specific allocation amongst damage, i.e., pain and suffering, lost wages, and medical claims. The State may also require that cases can only be compromised with the consent of the State.

- A State's lien laws may only operate to recover from that portion of a settlement that is allocated to healthcare items or services, even if it means that Medicaid must forego full recovery of its claim. According to *Ahlborn*, federal Medicaid anti-lien law precludes the State from passing lien laws which broaden the recovery rights of the State Medicaid agency. Note however, that the State may pass other laws which give it a priority right of recovery in tort actions.

State Actions Which Would Mitigate the Adverse Consequences of *Ahlborn*:

- In order to protect the Medicaid program's

interest in the allocation of settlement monies to medical items and services it is extremely important for States to be involved in the litigation and settlement process.

- States may pass laws which require mandatory joinder of a State when a Medicaid lien is at issue. The States may also want to strengthen their laws regarding the duty of attorneys to notify and cooperate to include provisions which could render voidable any settlement of which the State was not notified and given an opportunity to present its recovery claim for medical assistance paid. These actions are consistent with the federal Medicaid laws.

- As part of its governance of tort and insurance law, the State may enact laws which define tort rights of action, judicial procedures and settlement standards in State courts. For example, a State could enact laws which give priority to the repayment of medical expenses, only permit compromising a claim with the State's consent, or any other laws which ensure that the State will have an opportunity to fully recover its expenditures.

- The States may use the cost effectiveness criteria set forth in Section 1902(a)(25)(B) of the Act in determining which liability case settlements they should pursue for recovery of Medicaid claims. For example, where a

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GUIDANCE MEMO, July 3, 2006

Medicaid recipient decides not to pursue a claim, depending on the amount of the claim, the State Medicaid agency may determine that it is not cost-effective to pursue its direct right of recovery against the potentially liable party. States that choose this option should use the State plan process to adopt a threshold or other guidelines for determining whether to seek reimbursement. These actions are consistent with the federal Medicaid law.

- As part of its State plan, the State may determine that it is more cost-effective to pursue a lesser amount than the full cost of care in order to avoid litigation. Cost-effectiveness must be determined on a case by case basis. For example, the State could reduce the amount of its claim which becomes the amount of reimbursement that the State can reasonably expect to recover. However, in order to do so, a State must amend its State plan to include cost effectiveness criteria such as the following:

a. Factual and legal issues of liability as may exist between the Medicaid recipient and the liable party; and

b. Total funds, e.g., policy limits, available for settlement; and

CENTERS FOR MEDICARE & MEDICAID SERVICES
GUIDANCE MEMO, July 3, 2006

c. An estimate of the cost to the Medicaid program of pursuing its claim.

See the attached copy of general cost effectiveness criteria and Washington's State plan concerning third party liability and cost-effectiveness.

- The Medicaid statute does not require the State to repay the federal government its full federal share, i.e., the total amount the federal government expended, where the State has determined that it is not cost-effective to attempt to recover the full cost of care from a recipient's settlement. What the Medicaid statute does require is that the federal share of the State's actual recovery amount be repaid to the federal government. Such an action is not considered a compromise of the federal share for purposes of third party liability recovery. These actions are consistent with the federal Medicaid laws and the federal share would be based on the amount that is actually recovered by Medicaid.

Attachments (2)
Fact Sheet – June 2000
Washington SPA 99-07

CENTERS FOR MEDICARE & MEDICAID SERVICES
GUIDANCE MEMO, July 3, 2006

PURSUING TORT RECOVERIES

FACT SHEET

June 2000

Under section 1902(a)(25) of the Social Security Act (the Act), in either an out-of-court settlement or a court judgment, the State must do all in its power to obtain full restitution of the amounts expended on the beneficiary's behalf. Judgments or settlements will often contain more than just payment for the cost of medical care, such as pain and suffering or loss of consortium. Although the beneficiary may have been awarded a certain amount, pursuant to sections 1902(a) (45) and 1912(a)(1)(A) of the Act, the beneficiary has assigned to the State any rights to payment for medical care from any third party payer. Thus, the State has claim to the entire judgment or settlement amount to the extent of such legal liability.

Federal law and regulations do not permit a compromise, settlement, or release of any claim in whole or in part, allowing a Medicaid beneficiary to retain any funds, so long as the Federal government has not been reimbursed its share of the amount recovered by Medicaid. Some States contend that beneficiaries are unwilling to cooperate in recovery actions where they will not receive a share of the settlement/judgment. We offer three options that States may use that could result in monies being

distributed to the beneficiary. States are not obligated to elect any of these options.

OPTION I - APPLYING COST EFFECTIVENESS CRITERIA

Section 1902(a)(25)(B) includes a cost effectiveness aspect to any third party recovery. Specifically, the statute states:

> "in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability."

By applying 1902(a)(25)(B) as a basis, a State may determine that it is more cost-effective to pursue a lesser amount than the full cost of care in order to avoid either full litigation or the State pursuing the claim itself. In other words, the State could reduce the amount of its claim which becomes the "amount of reimbursement that the State can reasonably expect to recover." Thus, the State may pursue a reduced claim to the extent that it is cost-effective to do so. The Federal share would be based on the amount that is actually recovered by Medicaid.

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While a State may forego recovery efforts where it can be shown that such efforts would not be cost-effective, it may not operate under rules which, in every case, allow beneficiaries to retain third party liability payments where the Federal share of Medicaid expenditures has not been reimbursed. Cost-effectiveness is to be determined on a case-by-case basis. The State plan must describe the process by which the Medicaid agency determines that seeking full recovery of reimbursement would not be cost-effective.

OPTION 2- ALLOWANCE FOR ATTORNEY FEES AND COSTS

Attorney fees and litigation costs may be deducted prior to reimbursement to the Medicaid program. Although a State may choose to pay its share of the costs for attorney fees, it is not obligated to do so. The State may decide that the attorney fees will be deducted off the top and that the State will seek full recovery based on the remaining amount to be distributed. The following example illustrates a situation where the State **does not** share the costs.

State Does Not Share in Attorney Fees and Costs

Medicaid Lien Amount	$140,000
Amount of Third Party (TP) Payment	$200,000
Attorney Fees and Costs	- 50,000
Amount to be Distributed	$150,000

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Using this method, the $150,000 should be distributed as follows:

Medicaid Net Recovery (no adjustment) $140,000
Potentially Available to Beneficiary $ 10,000

While the Federal law does not mandate that States do so, it does allow States the flexibility to share a proportionate cost of legitimate attorney fees and litigation and witness costs. The amount of the reduction is calculated by the application of the ratio of the amount recovered by Medicaid to the entire third party payment amount and then multiplied by the amount of attorney fees. The following example illustrates a situation where the State **does** share the costs.

State Shares in Attorney Fees and Costs

Medicaid Lien Amount	$140,000	
Amount of TP Payment		$200,000
Medicaid's Share	$140,000	
Beneficiary's Share	$ 60,000	
Attorney Fees and Costs		- 50,000

Medicaid's share is 70% of the TP payment
($140,000 divided by $200,000 = 70%)

Medicaid pays 70% of attorney fees
($50,000 x 70% = $35,000)
Medicaid's Share of Attorney Fees $35,000

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GUIDANCE MEMO, July 3, 2006

Beneficiary's share is 30% of the TP payment
($60,000 divided by $200,000 = 30%)

Beneficiary pays 30% of attorney fees
($50,000 x 30% = $15,000)
Beneficiary's Share of
Attorney Fees $15,000

Amount to be Distributed $150,000

Medicaid's share of the TP payment minus
attorney fees
($140,000 - $35,000 = $105,000)
Medicaid's Net Recovery **$105,000**

Beneficiary's share of the TP payment minus
attorney fees
($60,000 - $15,000 = $45,000)
Potentially Available to Beneficiary
$ 45,000

Federal financial participation is available to share in attorney fees and cost. In the above example, the State would be required to return the Federal share based on the $105,000 that Medicaid recovered after adjusting for attorney fees and costs.

Applying this methodology, if the Medicaid lien amount is equal to or greater than the third party payment amount, the attorney's fees are paid from Medicaid's share and there is nothing left to disburse to the beneficiary. For example, if the Medicaid lien amount were $200,000 or greater and the third party

payment is $200,000, the attorney's fees would be deducted from the $200,000 and the remaining $150,000 would go to Medicaid.

OPTION 3- COMPROMISING THE STATE SHARE

The Federal government is to be made "whole" to the extent of its share of the amount recovered by the State. To the extent that a State wishes to give part or all of its portion of the Medicaid recovery to the beneficiary, nothing prevents the State from doing so as long as it does not impinge upon the Federal share of the amount recovered by Medicaid.

If in spite of its best efforts, a lesser amount is obtained/awarded, the State should be found in compliance with Federal requirements as long as it has followed HCFA's policy and has documented its efforts explaining why less than full recovery has been accepted.

[ATTACHMENT WASHINGTON SPA 99-07
OMITTED IN PRINTING]

CENTERS FOR MEDICARE & MEDICAID SERVICES
REPLY MEMO, DEC. 23, 2009

APPENDIX K

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta. Georgia 30303-8909 [LOGO OMITTED]

Reference:112420094050

December 23, 2009

The Honorable Howard Coble
Member, U.S. House of Representatives
P.O. Box 812
Graham, NC 27253-0812

Dear Mr. Coble:

This is in reply to your November 16, 2009 letter regarding you inquiry on behalf of your constituent Mr. David Andrew. Mr. Andrew is requesting restoration of excess Medicaid payment collected by North Carolina Medicaid in the case of his daughter Katelyn Andrews.

Mr. Andrews contends that the North Carolina Division of Medical Assistance (DMA) has ignored the Centers for Medicare & Medicaid Services (CMS) policy stated in a memorandum to CMS Associate Regional Administrators for Medicaid and State Operations dated July 6, 2006, in regard to the U.S. Supreme Court's decision in Arkansas Department of Human Services v. Ahlborn. The decision held that the

CENTERS FOR MEDICARE & MEDICAID SERVICES
REPLY MEMO, DEC. 23, 2009

State's recovery is limited to the settlement amount allocated for medical items and services.

The CMS guidance said, in part:

- "The Court ruled against the State, in this case, in which the Federal government had filed an amicus brief, holding that the Federal assignment and lien provisions prohibited full recovery of the State's payments for Medicaid if the State's recovery claim exceeded the amount designated as compensation for medical items and services. States must comply with the decision in Ahlborn."

- "Prior to the Supreme Court's decision in Ahlborn, CMS interpreted the Medicaid third party liability provision to authorize States to pass laws permitting full recovery of Medicaid assistance payments from third party liability settlements, regardless of how the parties allocated the settlement. The Supreme Court rejected this interpretation of the Medicaid statute and held that to the extent State laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of Federal Medicaid laws."

The purpose of the CMS memorandum was to provide States with mitigating strategies to minimize the

CENTERS FOR MEDICARE & MEDICAID SERVICES
REPLY MEMO, DEC. 23, 2009

adverse effects of the Ahlborn decision. We do not see any evidence that DMA has disregarded the CMS memo dated July 3, 2006.

- While the U.S. Supreme Court held that the Federal statute only permits a State to recover its payments for medical assistance from the portion of a liability settlement attributable to medical items and services, the Court did not mandate a specific method for determining the medical expense portion of a plaintiff's settlement.

- States have leeway to develop a reasonable statutory scheme for apportioning medical expenses.

- Rather than requiring a specific determination of the medical expense portion of a settlement, North Carolina addresses the allocation of medical expenses by limiting the amount of recovery by the State to no more than one-third of the gross amount obtained or recovered.

- The State Supreme Court held that the statutory one-third limitation complies with Ahlborn's interpretation of Federal law.

- U.S. Supreme Court affirmed the North Carolina Supreme Court decision by denying Mr. Andrews' petition for cert.

CENTERS FOR MEDICARE & MEDICAID SERVICES
REPLY MEMO, DEC. 23, 2009

We agree with the decision and find that neither the State's action nor the Court's decision conflict with CMS' guidance.

If you have any questions, please contact Rita Nimmons, of my staff, at (404) 562-7415.

Sincerely,

/s/ Trina Roberts for

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

OPPOSITION BRIEF

RECORD
AND
BRIEFS

No. 12-98

In the Supreme Court of the United States

ALBERT A. DELIA, SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

E.M.A. (BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON), WILLIAM EARL ARMSTRONG AND SANDRA ARMSTRONG,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR RESPONDENTS IN OPPOSITION

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August 2012

*Counsel of Record

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Law Library

QUESTION PRESENTED

Does the anti-lien provision of the federal Medicaid laws, 42 U.S.C. § 1396p(a), preempt North Carolina General Statutes Section 108A-57, which purports to create a lien upon any tort settlement received by a Medicaid recipient from a third-party up to one-third of the settlement?

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No. 12-98

In the Supreme Court of the United States

ALBERT A. DELIA, SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

E.M.A. (BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON), WILLIAM EARL ARMSTRONG AND SANDRA ARMSTRONG,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR RESPONDENTS IN OPPOSITION

STATEMENT

1. North Carolina, like all other States, voluntarily participates in the federal Medicaid program. As a result, the State of North Carolina has expressly agreed to be bound by the terms of that federal program. *See, e.g.*, 42 U.S.C. § 1396a; N.C. Gen. Stat. §§ 108A-54, -56.

The federal Medicaid program limits a State's ability to impose a lien upon the property of a Medicaid beneficiary. Specifically, the federal Medicaid Act authorizes such a lien in two narrowly defined circumstances: (1) a court has entered a judgment finding that benefits have been incorrectly paid to a beneficiary or (2) a beneficiary who owns real property is receiving inpatient services at a medical facility and certain specific requirements are met. 42 U.S.C. § 1396p(a)(1). This federal anti-lien provision states:

> *No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan*, except –
>
> (A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or
>
> (B) in the case of the real property of an individual * * * who is an inpatient in a * * * medical institution [and the patient] cannot reasonably be expected to be discharged from the medical institution and to return home * * * *

42 U.S.C. § 1396p(a)(1) (emphasis added).

2. Respondent Emily M. Armstrong[1] is a twelve year old girl who lives with her parents in Taylorsville, North Carolina. As a result of malpractice by the physician who delivered her at birth, Emily is deaf, blind, unable to sit, walk, crawl or talk and suffers from mental retardation and a seizure disorder. Pet. App. 5a. Based on her extensive pain and suffering, loss of enjoyment of life, loss of earning capacity and future medical expenses, Emily incurred damages far in excess of $42 million as a result of her physician's malpractice. *See* 4th Cir. J.A. 179-80.

In February 2003, Emily's guardian ad litem brought a malpractice action against Emily's treating physician and others in North Carolina state court. Despite Emily's catastrophic injuries, a settlement of $2.8 million was agreed upon at a mediation conference. This negotiated amount was significantly influenced by considerations of limited available medical malpractice insurance coverage and the challenges generally associated with collecting a judgment from the limited assets of an individual. Based on all of the surrounding circumstances, the state superior court judge

---

[1] Emily's full name is set out in the published opinion of the district court, as well as published opinions of the North Carolina appellate courts in the underlying tort action. *See, e.g.*, 722 F. Supp. 2d 653; *Armstrong v. Barnes*, 614 S.E.2d 371 (N.C. Ct. App.), *discr. review denied*, 621 S.E.2d 173 (N.C. 2005); *see also North Carolina Dep't of Health & Human Servs. v. Armstrong*, 690 S.E.2d 293 (N.C. Ct. App. 2010) (abating state court action during pending federal action). Pursuant to Fourth Circuit Local Rule 25(c)(3)(C), however, Emily was referred to by her initials "E.M.A." in all filings before the Fourth Circuit.

concluded that the settlement agreement "is fair and just, is in the best interest of the minor plaintiff Emily M. Armstrong, and is in all respects reasonable and proper." 4th Cir. J.A. 134.

Following the filing of the medical malpractice action by Emily's guardian ad litem, Petitioner North Carolina Department of Health and Human Services ("NC DHHS") asserted a statutory lien on any settlement proceeds resulting from that action. NC DHHS based its claim of lien upon N.C. Gen. Stat. § 108A-57(a) which provides:

> [T]he State * * * shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance * * * * Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but *the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.*

N.C. Gen. Stat. § 108A-57(a)(emphasis added). NC DHHS made its assertion of a statutory lien: (1) even though there was no "judgment of a court on account of benefits incorrectly paid on behalf of" Emily, *see*

42 U.S.C. § 1396p(a)(1)(A), and (2) even though Emily owns no real property nor is she an inpatient in a medical facility, *see* 42 U.S.C. § 1396p(a)(1)(B). As a result of NC DHHS' purported lien, the state superior court judge directed that one-third of the settlement payment (i.e., the sum of $933,333.33) be paid to the Clerk of Court and placed in an interest bearing account "until such time as the actual amount of the lien owed by Emily Armstrong to [NC DHHS] is conclusively judicially determined." 4th Cir. J.A. 230; *see* Pet. App. 4a.

3. Following the entry of the state superior court order, Emily and her parents brought the present action in federal district court, seeking a declaratory judgment that the lien by NC DHHS was preempted by the federal Medicaid Act, 42 U.S.C. § 1396p(a). The complaint alleges that NC DHHS' assertion of a lien is inconsistent with the anti-lien provision of the federal Medicaid laws and this Court's decision in *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006). 4th Cir. J.A. 13. The complaint prays that the court declare N.C. Gen. Stat. § 108A-57 to be unconstitutional. 4th Cir. J.A. 18. The district court proceeded to stay discovery pending the appeal before the North Carolina Supreme Court in *Andrews v. Haygood*, 57A07-2, which raised similar challenges to the North Carolina statute. Pet. App. 74a.

On December 12, 2008, the North Carolina Supreme Court rendered its decision in *Andrews v. Haygood*, 669 S.E.2d 310 (N.C. 2008), *cert. denied*, 129 S. Ct. 2792 (2009). Relying upon a presumption that state statutes are constitutional, the North

Carolina Supreme Court, in a 4-3 decision, held that N.C. Gen. Stat. § 108A-57 is not preempted by federal law. Pet. App. 96a. The North Carolina Supreme Court distinguished this Court's decision in *Ahlborn* in that the *Ahlborn* decision involved a stipulation by the parties as to the reasonable value of the plaintiff's total claim for damages. Pet. App. 93a ("*Ahlborn* thus controls when there has been a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement.").

In *Andrews*, the North Carolina Supreme Court concluded that N.C. Gen. Stat. § 108A-57 "comports with *Ahlborn* by providing a reasonable method for determining the State's medical reimbursements." Pet. App. 95a. The majority in *Andrews* opined that allowing NC DHHS to take one-third of all tort settlements without having to determine the actual proportion between various categories of damages would "promot[e] efficiency in Medicaid reimbursement." Pet. App. 95a. Justice Hudson, joined by Justices Brady and Timmons-Goodson, dissented. She reasoned that "*Ahlborn* is binding upon this Court, and its reasoning and holding compel the conclusion that the application of N.C. Gen. Stat. § 108A-57 here, without any further determination of how the settlement proceeds were allocated among different types of damages alleged by plaintiff, would be contrary to federal law." Pet. App. 101a (Hudson, J., dissenting).

The federal district court below adopted the reasoning of the majority in *Andrews* and granted summary judgment in favor of NC DHHS. Citing footnote 18 of this Court's decision in *Ahlborn*, the

district court reasoned that the *Ahlborn* decision leaves open the possibility that a State could "'adopt[] special rules and procedures for allocating tort settlements.'" Pet. App. 84a (quoting *Ahlborn*, 547 U.S. at 288, n.18). According to the district court, "North Carolina has adopted such a statutory scheme, which provides a reasonable method for ascertaining the State's medical reimbursements, while still protecting the interests of Medicaid recipients * * * *"

4. The Fourth Circuit reversed the district court, concluding that the irrebuttable presumption created by N.C. Gen. Stat. § 108A-57 is inconsistent with the *Ahlborn* decision. Pet. App. 52a (noting that *Ahlborn* cautions that if state rules and statutes provide a formula for allocating a settlement between past medical expenses paid by Medicaid and other categories of damages, States "must afford a mechanism permitting beneficiaries to rebut such a presumption"). The Fourth Circuit noted that "under the circumstances in this case, North Carolina's statutory presumption must be subject to adversarial testing." Pet. App. 53a. The Fourth Circuit concluded "the one-third cap on the state's recovery imposed by the North Carolina third-party liability statutes is in fatal conflict with federal law." Pet. App. 5a.

ARGUMENT

Petitioner contends that the Fourth Circuit erred in its construction of Medicaid's anti-lien provision. While there is a direct conflict between the Fourth

Circuit and the North Carolina Supreme Court on this issue, that conflict is of limited importance and will likely be resolved (either through the state supreme court reconsidering its decision or through state legislative amendments) in the near future without the necessity for intervention by this Court. The Fourth Circuit correctly concluded that the irrebuttable presumption created by the state statute at issue runs afoul of both the federal Medicaid Act and this Court's decision in *Ahlborn*. Further review is not warranted.

I. THE LIMITED SPLIT OF AUTHORITY DOES NOT WARRANT REVIEW BY THIS COURT AT THE PRESENT TIME.

The Petition correctly notes that the decision of the Fourth Circuit is in direct conflict with the decision of the North Carolina Supreme Court in *Andrews v. Haygood,* 669 S.E.2d 310 (N.C. 2008), *cert. denied,* 129 S. Ct. 2792 (2009). The split on this issue, however, is not substantial and does not merit review by this Court.

Consistent with this Court's decision in *Ahlborn*, two circuit courts and one state supreme court have held that Medicaid's anti-lien statute precludes States from enacting statutes that arbitrarily and irrebuttably allocate settlement proceeds as being payment for past medical expenses when, in actuality, those payments were made in order to compensate a tort victim for pain and suffering (and similar damages). *E.M.A. v. Cansler,* 674 F.2d 290 (4th Cir. 2012); *Tristani v. Richman*, 652 F.3d 360, 377-78 (3d Cir. 2011); *In re E.B.*, 2012 W. Va. LEXIS

314 (W. Va. 2012); *accord Southwest Fiduciary, Inc. v. Arizona Health Care Cost Containment Sys. Admin.*, 249 P.3d 1104, 1109 (Ariz. Ct. App. 2011); *Bolanos v. Superior Court*, 87 Cal. Rptr. 3d 174, 180 (Cal. Ct. App. 2008); *Lugo v. Beth Israel Med. Ctr.*, 819 N.Y.S.2d 892, 896 (N.Y. App. Div. 2006). The North Carolina Supreme Court has held to the contrary. *Andrews v. Haygood*, 669 S.E.2d 310 (N.C. 2008), *cert. denied*, 129 S. Ct. 2792 (2009); *accord Russell v. Agency for Healthcare Admin.*, 23 So. 3d 1266 (Fla. Dist. Ct. App. 2010); *Scharba v. Everett L. Braden, Ltd.*, 2010 U.S. Dist. LEXIS 40200 (M.D. Fla. 2010).

The North Carolina Supreme Court, of course, is not required to follow a decision by the Fourth Circuit construing federal law. *See, e.g., Security Mills of Asheville, Inc. v. Wachovia Bank & Trust Co.*, 189 S.E.2d 266, 269 (N.C. 1972). Nevertheless, the North Carolina Supreme Court almost universally falls in line with Fourth Circuit decisions relating to the construction of a federal statute. *See, e.g., Tillman v. Commercial Credit Loans, Inc.*, 655 S.E.2d 362, 369 (N.C. 2008) (adopting Fourth Circuit holding that arbitration agreement that is unconscionable may not be enforced); *Pender County v. Bartlett*, 649 S.E.2d 364, 380 (N.C. 2007) (adopting Fourth Circuit holding that vote dilution claim under Section 2 of the Voting Rights applies only to majority-minority districts), *aff'd*, 556 U.S. 1 (2009); *Watson v. American Nat'l Fire Ins. Co.*, 425 S.E.2d 696, 697 (N.C. 1993) (adopting Fourth Circuit construction of federal regulation); *Brooks v. McWhirter Grading Co.*, 281 S.E.2d 24, 34 (N.C. 1981) (adopting Fourth Circuit construction of OSHA

regulation); *see also In re Search Warrants*, 683 S.E.2d 418, 426 (N.C. Ct. App. 2009) ("Although we are not bound by federal decisions regarding constitutional rights, we find the Fourth Circuit's reasoning persuasive * * * *"), *discr. review denied*, 694 S.E.2d 201 (N.C. 2010); *Housecalls Home Health Care, Inc. v. State*, 682 S.E.2d 741, 745 (N.C. Ct. App. 2009) ("While we are not bound by decisions of the Fourth Circuit, we find [its] reasoning * * * persuasive * * * *"), *discr. review denied*, 690 S.E.2d 697 (N.C. 2010); *State v. Wheeler*, 688 S.E.2d 51, 56 (N.C. Ct. App.) ("We find the Fourth Circuit's analysis * * * informative and instructive in our consideration of the present case."), *discr. review denied*, 701 S.E.2d 677 (N.C. 2010).

The divided decision (4-3 split) of the North Carolina Supreme Court in *Andrews* and the two lower court decisions that have followed *Andrews* appear to be aberrations.[2] The North Carolina Supreme Court is likely to correct its erroneous decision after considering the Fourth Circuit's opinion and the recent criticisms of *Andrews*. *See In re E.B.*, 2012 W. Va. LEXIS 314, at *64; Note, *A Post-*Ahlborn *Analysis of the Supreme Court of North*

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[2] The North Carolina Supreme Court's decision appears to largely be the product of unfortunate timing. Two months after this Court issued the *Ahlborn* decision, the North Carolina Supreme Court in *Ezell v. Grace Hosp., Inc.*, 631 S.E.2d 131 (N.C. 2006), ruled that NC DHHS has a broad right of subrogation under N.C. Gen. Stat. § 108A-57(a). Remarkably, the North Carolina Supreme Court's ruling does not even cite to the *Ahlborn* decision. *See* Pet. App. 25a-26a. The court's ruling in *Ezell* appears to have greatly influenced the majority opinion in *Andrews*. *See* Pet. App. 96a.

Carolina's Decision in Andrews v. Haygood, 2 Charlotte L. Rev. 525, 542 (2010).

Subsequent to the Fourth Circuit's decision in the present case, NC DHHS has actively asserted liens under N.C. Gen. Stat. § 108A-57 in state court. *See, e.g., Race v. Evenflo Co.*, Case No. 09 CvS 4913 (N.C. Superior Court, Onslow County). If NC DHHS continues its practice of pursuing such liens in state court, the North Carolina Supreme Court will have ample opportunity to either re-affirm or overrule the *Andrews* decision. Moreover, the North Carolina Supreme Court will have the opportunity to reconsider *Andrews* in the context of the present dispute. In 2007, NC DHHS filed an action in state court against Respondents and requested an order directing disbursement of the funds being held by the court. *See North Carolina Dep't of Health & Human Servs. v. Armstrong*, 690 S.E.2d 293 (N.C. Ct. App. 2010). The North Carolina Court of Appeals held that NC DHHS' action should be abated. *Id.* Presumably, NC DHHS will move to re-activate that state court proceeding after the federal district court reaches an allocation.

Even if the North Carolina Supreme Court were to decline to reconsider *Andrews*, the issue may well be mooted if the North Carolina General Assembly were to enact clarifying legislation. Numerous commentators have urged the North Carolina General Assembly to do so. *See, e.g.*, Note, *A Post-*Ahlborn *Analysis, supra*, at 542; J. Saxon, *Medicaid "Liens" on Personal Injury Judgments and Settlement: The* Ahlborn *and* Ezell *Decisions*, Soc. Servs. L. Bulletin, No. 41, July 2006, at 18. Those

pleas have greater force in light of the decision below.

II. THE FOURTH CIRCUIT'S DECISION IS CONSISTENT WITH THIS COURT'S OPINION IN *AHLBORN*.

Petitioner's suggestion that review is necessary to correct an error in the decision below rings hollow. Pet. 13-19. The Fourth Circuit's opinion is consistent with both the federal Medicaid Act and this Court's decision in *Ahlborn*.[3]

In *Ahlborn*, this Court emphasized that Medicaid's anti-lien provision precludes States from

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[3] Petitioner implies that NC DHHS will, on occasion, "consent to compromise" with respect to the allocation of a tort settlement. Pet. 17. Pursuant to S. Ct. R. 15.2, Respondents dispute this statement. Prior to January 2011, NC DHHS' own manual stated that NC DHHS will *never* accept less than one-third of a tort settlement in satisfaction of its lien. NC DHHS, Third Party Recovery Manual, p. 17 ("*There is no circumstance in which a Medicaid lien can be waived.*"). It continues: "There is no authority in either Federal or State law to authorize Medicaid to compromise liens." *Id.* In a section entitled "Frequently Asked Questions," NC DHHS reiterates this position:

> QUESTION: My client has very severe injuries and will need very expensive medical care for the rest of his life. Would the Medicaid program consider reducing or waiving its lien so that my client will receive more money from the settlement?
>
> ANSWER: We do not waive or compromise liens.

Id. at 20.

recovering more than the "portion of a settlement that represents payment for medical care." 547 U.S. at 282. The Court concluded that States may not "demand reimbursement from portions of the settlement allocated or allocable to nonmedical damages." *Id.* at 291. States are simply given "a priority disbursement *from the medical expenses portion alone.*" *Id.* (emphasis added). The Fourth Circuit's decision faithfully follows this Court's pronouncements in *Ahlborn*.[4]

As the Fourth Circuit recognized, N.C. Gen. Stat. § 108A-57 creates an arbitrary, irrebuttable presumption with respect to the allocation between past medical expenses and other categories of damages. Such a presumption, however, has no basis in reality. *See, e.g.*, Pet. App. 20a. Moreover, because the presumption is irrebuttable, the formula (even if it were well-grounded) will result in the State recovering more than the "portion of a settlement that represents payment for medical care" in many individual cases. 547 U.S. at 282. The Fourth Circuit appropriately held that North Carolina's one-third cap does not satisfy *Ahlborn*.

Petitioner attempts to attack the Fourth Circuit's straight-forward application of the *Ahlborn* decision by relying on a December 23, 2009 letter from Mary Justis to Congressman Howard Coble. Pet. 17-18;

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[4] In *Ahlborn*, this Court assumed without deciding that the Medicaid Act authorizes States to impose a lien on tort settlements received from third-parties – but only with respect to the portion of the settlement that is attributable to medical expenses paid by the Medicaid program. 547 U.S. at 283-84.

Pet. App. 139a-42a. In that letter, Ms. Justis concludes that NC DHHS does not appear to have disregarded directives from the Centers for Medicare and Medicaid Services. Her conclusion is based largely upon her understanding that the United States Supreme Court "affirmed" the North Carolina Supreme Court's decision in *Andrews* by denying certiorari. Pet. App. 141a. Ms. Justis, who is a registered nurse and holds a Masters in Business Administration, is neither an attorney nor a judge. Pet. App. 142a. Her erroneous legal conclusion as to the effect of this Court's denial of certiorari is not entitled to deference as NC DHHS suggests. *See* Pet. 18.

The Fourth Circuit's decision was correctly decided. Review is not warranted to correct an error below.

III. THE PETITION RAISES AN ISSUE THAT WILL HAVE MINIMAL IMPACT OUTSIDE OF NORTH CAROLINA.

The issue raised by the petition has only a minimal impact upon a handful of jurisdictions at best. Subsequent to this Court's decision in *Ahlborn*, numerous States amended their lien statutes to conform to that decision. Pet. App. 47a-48a; *see Price v. Wolford*, 608 F.3d 698, 706 (10th Cir. 2010); *Burtsell v. Toumpas*, 2012 U.S. Dist. LEXIS 65636, *11 (D.N.H. 2012); *E.D.B. v. Clair*, 987 A.2d 681, 686 n.5 (Pa. 2009); *Bolanos v. Superior Court*, 87 Cal. Rptr. 3d 174, 176 (Cal. Ct. App. 2009). Nevertheless, Petitioner argues that certiorari should be granted because he believes that the Fourth Circuit's

decision creates "ongoing uncertainty over the viability of other statutory provisions" throughout the country. Pet. 21. Such concerns are unfounded.

The petition notes that five other States have a statutory cap similar to North Carolina. Pet. 19. Four of these States set their cap at 50 percent. One (Minnesota) uses one-third. Simply because these five States have not yet revised their statutes to conform to the *Ahlborn* decision, however, does not give rise to an issue of such importance as to merit plenary review by this Court. Moreover, the assertion that the petition raises an issue important to other States is belied by the fact that *no* State has filed an amicus brief urging the Court to grant review in this case.

In an effort to bolster the significance of the question presented, Petitioner relies upon a string citation of 26 state statutes which he opines may not withstand scrutiny under the Fourth Circuit's decision. Pet. 19-20. These statutes, however, simply provide a generic statement, consistent with 42 U.S.C. § 1396a, that acceptance of Medicaid benefits constitutes an assignment of rights with respect to third parties. A close examination of the listed statutes reveals that none would be preempted under the Fourth Circuit's reasoning below.

IV. THE PETITION IS A POOR VEHICLE FOR RESOLVING THE ISSUE PRESENTED.

Two separate factors make the present petition a poor vehicle for resolving the question presented.

First, Medicaid's anti-lien statute permits a lien only in two narrow circumstances: (1) a court has entered a judgment finding that benefits have been incorrectly paid to a beneficiary or (2) a beneficiary who owns real property is receiving inpatient services at a medical facility and certain specific requirements are met. 42 U.S.C. § 1396p(a)(1). Neither of these circumstances is applicable here. As this Court observed in *Ahlborn*, "[r]ead literally and in isolation, the anti-lien prohibition contained in § 1396p(a) would appear to ban even a lien on that portion of the settlement proceeds that represents payment for medical care." 547 U.S. at 284. In *Ahlborn*, the Court assumed without deciding that Congress in fact intended 42 U.S.C. § 1396p(a) to be broader than its literal language: "[W]e assume, as do the parties, that the State can * * * demand as a condition of Medicaid eligibility that the recipient 'assign' in advance any payments that may constitute reimbursement for medical costs." 547 U.S. at 284.

In deciding whether N.C. Gen. Stat. § 108A-57 is preempted by Medicaid's anti-lien provision, Pet. i, the Court should first determine whether the reach of § 1396p(a) is in fact broader than the literal language of the words chosen by Congress. Although this issue falls within the scope of the question presented, the issue, however, was not argued before or ruled on by the lower courts. *See* Pet. App. 19a n.4. The fact that this threshold issue was not adequately developed below makes the present petition less than an ideal vehicle for determining the question presented.

Second, the Fourth Circuit's decision merely remands the matter to the district court for "an evidentiary hearing at which the district court shall determine the proper amount of DHHS's Medicaid lien." Pet. App. 55a. Until that evidentiary hearing is conducted, it is impossible to determine whether Petitioner's lien will ultimately be any less than the $933,333.33 it is currently claiming. At the evidentiary hearing before the district court, Petitioner will attempt to convince the district court that the proper amount of NC DHHS' Medicaid lien should still be one-third of the total settlement. Pet. 9 & n.2. Thus, the petition may ultimately present a question that is merely an academic exercise. Until such time as the parties know whether NC DHHS' lien will ultimately be set at a sum less than the lien amount provided in N.C. Gen. Stat. § 108A-57, consideration of the constitutionality of the North Carolina statute by this Court would appear to be premature and unnecessary.

CONCLUSION

The petition for writ of certiorari should be denied.

Respectfully submitted,

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REPLY BRIEF

No. 12-98

In the
Supreme Court of the United States

ALBERT A. DELIA, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

E.M.A., a Minor, by and through her Guardian ad Litem, DANIEL H. JOHNSON, WILLIAM EARL ARMSTRONG and SANDRA ARMSTRONG,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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September 2012

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ARGUMENT

The court of appeals' determination that North Carolina's third-party recovery statute is preempted by the Medicaid Act's anti-lien provision warrants this Court's review. That decision is in direct conflict with a prior decision by the North Carolina Supreme Court which expressly held that the North Carolina statute comported with the Medicaid Act as it was construed in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006). This case presents important issues for North Carolina as well as for other States that were not addressed in *Ahlborn* and should be decided by the Court. Respondents' arguments to the contrary lack merit.

1. Respondents approach this case as if it only involved a dispute over the amount of money recoverable from a single Medicaid recipient's tort claim settlement, with the decision of the Fourth Circuit merely the law of the case. Their unpersuasive attempt to minimize the significance of the issue presented is demonstrated by their characterization of the undeniable direct conflict with the prior decision of the North Carolina Supreme Court as "of limited importance" and their assertion, based on unexplained clairvoyance, that the conflict "will likely be resolved (either through the state supreme court reconsidering its decision or through state legislative amendments) in the near future." (Br. in Opp. 8)

a. As previously detailed, acceptance of the case for review is necessary not only to resolve a direct conflict between the Fourth Circuit and the North

Carolina Supreme Court but also to address for the benefit of all States the important issue not reached in *Ahlborn* – the extent to which States are allowed to utilize special rules and procedures for allocating tort settlements under the Medicaid Act. (Pet. 10-12)

The Fourth Circuit ruled that the States have only one method of combating settlement manipulation–the use of "mini hearings" – and therefore concluded that application of North Carolina's statutory procedure to an unallocated lump-sum settlement violated the Medicaid Act's anti-lien provision. (Pet. App. 45a) The decision misconstrues guidance from the Centers for Medicare and Medicaid Services ("CMS") for the proposition that State laws are prohibited under *Ahlborn* if they "permit recovery over and above what the parties have appropriately designated as payment for medical items and services."[1] (Pet. App. 46a) The Fourth Circuit's holding has wide-ranging application to all States and, as previously explained, has been

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[1] This statement takes out of context language from the *Ahlborn* decision noting that Arkansas had conclusively stipulated to the portion of the settlement proceeds that were "properly . . . *designated* as payments for medical costs." 547 U.S. at 288 (emphasis added). In proper context, the use of the word "designated" refers to the agreed stipulation and offers no support for the contention that a plaintiff and a tortfeasor have the power to "designate" which portion (if any) of a settlement can be recovered by the State as reimbursement for the payment of past medical expenses.

relied upon in a recent decision by the Supreme Court of Appeals of West Virginia. (Pet. 20-21)

b. Respondents' assertion that the Petition does not merit the time and attention of the Court because North Carolina's judicial and/or legislative branches are "likely" to resolve the conflict by accepting the analysis of the Fourth Circuit either in a subsequent court decision or in amended legislation is wholly speculative and does not withstand scrutiny.

First, Respondents' statement that the North Carolina Supreme Court "almost universally falls in line with Fourth Circuit decisions" has no relevance here. (Br. in Opp. 9) That observation merely reflects the unremarkable concept that a federal court's interpretation of statutory provision is frequently persuasive. None of the cases cited by Respondent involved anything analogous to the situation here where the North Carolina Supreme Court would be reconsidering and reversing one of its own decisions to conform to a subsequent decision of the Fourth Circuit.[2] There is no guarantee that an opportunity to

---

[2] Respondents' citation to three decisions by the North Carolina Court of Appeals for the proposition that decisions by the Fourth Circuit are persuasive is particularly inappropriate. (Br. in Opp. 10) The North Carolina Court of Appeals has no "authority to overrule decisions of the Supreme Court of North Carolina" because "its responsibility [is] to follow those decisions until otherwise ordered by the Supreme Court." *Cannon v. Miller*, 313 N.C. 324, 327 S.E.2d 888 (1985) (per curiam).

revisit the matter will be presented, because a case presenting the legal issue would have to make its way through the trial and intermediate appellate levels. And even if a case did, the North Carolina Supreme Court firmly recognizes the policy of *stare decisis* and does not routinely overrule itself. All of the Justices that formed the majority for the decision in *Andrews v. Haygood*, 362 N.C. 599, 669 S.E.2d 310 (2008), *cert. denied sub nom. Brown v. North Carolina Department of Health and Human Services*, 129 S. Ct. 2792 (2009), remain on the bench, and there is no proper basis to claim that it is "likely" the legal analysis and conclusion will be diametrically different in a hypothetical future case.

Second, the suggestion that the case "may well be mooted if the North Carolina General Assembly were to enact clarifying legislation" is truly remarkable. (Br. in Opp. 11) This reason to deny review would necessarily apply in any and every case where the issue presented involves a state statute invalidated by a federal court. Any asserted likelihood of such legislative action is rank speculation.

2. Respondents argue that the decision of the Fourth Circuit is consistent with the holding in *Ahlborn*, which they characterize as simply giving

States a priority disbursement from the portion of a settlement that represents medical expenses alone.[3] (Br. in Opp. 13) They further contend that North Carolina's statutory formula "will result in the State recovering" more than it should in many individual cases, reinforcing their previous assertion that the statute allows the NC DHHS "to take one-third of all tort settlements."[4] (Br. in Opp. 13, 6)

---

[3] Respondents rely on *Ahlborn's* discussion of decisions by the Departmental Appeals Board of HHS in two matters specifically limited to the question of whether § 1396k(b) (the Medicaid Act assignment statute), standing alone, "authorize[d] the State to demand reimbursement from portions of the settlement allocated or allocable to nonmedical damages." 547 U.S. at 291.

[4] Respondents mischaracterize the Petition as "impl[ying] that NC DHHS will, on occasion, 'consent to compromise' with respect to the allocation of a tort settlement." (Br. in Opp. 12 n.3) The excerpted language comes from the statement that "North Carolina's subrogation statute provides the state's consent to compromise by automatically reducing its claim to one-third of the recovery if the recovery does not equal at least three times the amount of the Medicaid lien." (Pet. 17) In proper context, the statement is wholly consistent with the previous unchallenged statement that North Carolina's statutory provisions "provide an advance agreement that the State will reduce its lien if the amount of the Medicaid lien exceeds one-third of the total recovery." (Pet. 14-15)

As previously detailed, a proper reading of *Ahlborn* establishes that states retain the authority to regulate how tort recoveries must be allocated, and that the Fourth Circuit erroneously imposed a requirement for an "adversarial hearing" to determine the "true value" of the case before allocating a portion of a settlement as compensation for past medical expenses. (Pet. 13-16) *Ahlborn's* mere suggestion of court review does not support the Fourth Circuit's imposition of a requirement for an evidentiary hearing to establish what portion of settlement proceeds are properly allocable to past medical expenses, especially in light of other language in the opinion leaving open the option for States to adopt special rules and procedures to meet concerns about settlement manipulation.

The Petition further demonstrates how the Fourth Circuit misread guidance from CMS, detailing the relevant provision of a 2006 CMS Memorandum as well as a subsequent 2009 Reply Memo which addressed the question of whether the North Carolina Supreme Court's decision in *Andrews* was in conflict with the guidance set forth in the 2006 CMS Memorandum. (Pet. 16-19) Respondents have no substantive response to the issue regarding the CMS directives; instead, they choose to attack the author of the 2009 Reply Memo, dismissing the matter because she is merely a "registered nurse" who "holds a Masters in Business Administration" but "is neither an attorney nor a judge." (Br. in Opp. 14) It is difficult to understand how the views of any agency regarding a statute it administers could meet Respondents'

standard that they be expressed by a member of the judiciary.

Respondents have not and cannot dispute that the Reply Memo was a response to an inquiry from a member of Congress from an administrator of CMS in her official capacity and clearly demonstrates the misplaced reliance by the Fourth Circuit on the 2006 CMS policy statement to support its erroneous conclusion. The 2009 Reply Memo correctly notes that consistent with the 2006 CMS Memorandum "States have leeway to develop a reasonable statutory scheme for apportioning medical expenses" and concludes that North Carolina's actions as reviewed in *Andrews* are not in "conflict with CMS' guidance." (Pet. App. 141a, 142a)

North Carolina's statutory provision comports with *Ahlborn* because, as held by the district court, it "provides a means of calculating that portion [of a settlement representing payment for medical expenses], and then forbids the State from imposing a lien on the remainder of the settlement." (Pet. App. 82a)

3. The Petition addresses why the important issue presented should be decided by the Court, including an outline of other State statutory procedures that may be called into question under the analysis of the Fourth Circuit, as well as noting a request for guidance from a State court that recently relied upon the Fourth Circuit decision. (Pet. 19-21) Respondents attempt to diminish the importance of the issue presented by

claiming that the statutes cited in the Petition similar to North Carolina merely represent "States [that] have not yet revised their statutes to conform to the *Ahlborn* decision." (Br. in Opp. 15) As to the 26 other State statutes referenced, Respondents describe them as "simply provid[ing] a generic statement . . . that acceptance of Medicaid benefits constitutes an assignment of rights with respect to third parties," and boldly assert that "[a] close examination of the listed statutes reveals that none would be preempted under the Fourth Circuit's reasoning." (Br. in Opp. 15)

As expressly set forth in the Petition, the relevance of the referenced provisions is that the listed State statutes "do not require an 'adversarial testing' of the allocation of damages of the type mandated by the decision of the Fourth Circuit." (Pet. 19-20) Respondents have not and cannot demonstrate why a decision requiring a procedure whereby a Medicaid recipient can challenge the amount of a Medicaid third-party recovery which does not exist in any of the listed States' third-party recovery statutes "has only a minimal impact upon a handful of jurisdictions at best." (Br. in Opp. 14)

All States, by virtue of participation in the Medicaid program, are required to seek reimbursement from third-party tortfeasors, and acceptance of this case for review is appropriate and necessary to address the post-*Ahlborn* uncertainty as to what "special rules and procedures for allocation of tort settlements" are permitted by the Medicaid Act.

4. Respondents attempt to dissuade the Court from accepting the case for review, asserting that the petition is "less than an ideal vehicle for determining the question presented." They contend that the Petition does not adequately present the "threshold issue" of whether the Medicaid Act's anti-lien provision allows States to impose a lien on even the portion of tort settlements received from third-parties attributable to expenses paid by Medicaid, and that the Fourth Circuit's remand of the case to district court for an evidentiary hearing on the amount of North Carolina's Medicaid lien renders review by the Court "premature and unnecessary." (Br. in Opp.13 n.4, 16, 17) Neither argument withstands scrutiny.

a. Respondents' claimed "threshold issue" was addressed in *Ahlborn*. And, to the extent it was not presented and developed below, Respondents are directly responsible for any shortcomings regarding presentation of the purported necessary preliminary question regarding the scope of the Medicaid Act's anti-lien provision.

First, Respondents' argument requires that the anti-lien provision, 42 U.S.C. § 1396p(a), be "[r]ead literally and in isolation," an argument specifically rejected by the Court in *Ahlborn*. 547 U.S. at 284. Respondents' contention that the Court "assumed without deciding" that a State could impose a lien on the portion of a third-party settlement that constitutes reimbursement for medical costs paid by Medicaid ignores the clear statements made in *Ahlborn* that

address the question. (Br. in Opp. 13 n.4, 16) The *Ahlborn* Court found that Medicaid's "third-party liability provisions *require* an assignment" of the right to recover that portion of a settlement that represents payment for medical care, 547 U.S. at 282, declaring "[t]here is no question that the State can require an assignment" of a Medicaid recipient's right to receive payments for medical care, and that the State's prerogative is "expressly provided" for in the third-party recovery provisions of the Medicaid Act. *Id.* at 284. The Court concluded that "[t]o the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision." *Id.*

In proper context, the specific third-party recovery requirements for health-care expenditures imposed by the Medicaid Act must be read as an express exception to the general anti-lien provision, as the Act provides for a proper State lien on the portion of a tort settlement constituting reimbursement for medical costs. That is how the relevant statutory provisions were read in *Ahlborn*, and Respondents have not and cannot show that any court in any jurisdiction has read them differently.

Second, any failure of the court below to address the proper scope of the Medicaid anti-lien provision as a necessary "threshold issue" is directly attributable to the litigation strategy adopted and utilized by Respondents. The only way the purported necessary preliminary question – whether the Medicaid Act's

anti-lien provision allows States to impose a lien on even the portion of tort settlements received from third-parties attributable to expenses paid by Medicaid – could have been ruled upon is if it had been properly presented in the trial court pleadings.

Here, Respondents' Complaint sought declaratory relief to the extent North Carolina's third-party recovery statutes allowed the State "to assert a lien on settlement funds paid in lieu of damages for claims other than medical expenses." (Pet. App. 9a) Indeed, as noted by the Fourth Circuit, "[t]he parties before us do not dispute the state's entitlement to *some* reimbursement from the lump-sum settlement." (Pet. App. 4a)

Plainly, the Complaint did not raise and Respondents did not litigate in any way the question of whether the State could properly assert a statutory lien on any portion of the settlement proceeds. The failure of Respondents to raise that issue below should not provide a procedural shield against North Carolina's attempt to have this Court accept for review the important issue presented by the decision of the Fourth Circuit.

b. Respondents suggest that the Court's consideration of the question presented concerning the constitutionality of N.C. Gen. Stat. § 108A-57 would be premature because the case has been remanded by the Fourth Circuit to the district court for a determination of the proper amount of Petitioner's lien. (Br. in Opp. 17) Respondents' approach ignores the

jurisprudential effect of the Fourth Circuit's declaration that North Carolina's third-party recovery statutes "fail to comply with federal Medicaid law" such that when there is an unallocated lump-sum settlement "the sum certain allocable to medical expenses must be determined by way of a fair and impartial adversarial procedure." (Pet. App. 54a, 55a)

Respondents' attempt to defer a decision on the issue presented misses the point. A determination of the precise monetary amount of North Carolina's Medicaid lien under the facts and circumstances presented does not obviate the various holdings in the case. Nothing that occurs in the district court on remand can or will change the legal issues decided by the Fourth Circuit or diminish their precedential impact.

The express, fundamental conflict between the Fourth Circuit and the North Carolina Supreme Court as to the constitutional viability of North Carolina's third-party recovery statute and the question squarely presented in this petition – whether N.C. Gen. Stat. § 108A-57 is preempted by the Medicaid Act's anti-lien provision as it was construed in *Ahlborn* – will remain until resolved by this Court.

CONCLUSION

For the foregoing reasons, and those stated in the petition for a writ of certiorari, the petition should be granted.

Respectfully submitted,

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September 2012

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JOINT APPENDIX

RECORD
AND
BRIEFS

Supreme Court, U.S.
FILED
NOV 9 - 2012
OFFICE OF THE CLERK

No. 12-98

IN THE

Supreme Court of the United States

ALBERT A. DELIA, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

E.M.A., A MINOR, BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON, WILLIAM EARL ARMSTRONG AND SANDRA ARMSTRONG,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

JOINT APPENDIX

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PETITION FOR WRIT OF CERTIORARI FILED JULY 20, 2012
CERTIORARI GRANTED SEPTEMBER 25, 2012

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NOTICE

The following opinions, decisions, judgments, orders, statutes, and secondary sources have been omitted in printing this joint appendix because they appear at the following page in the Appendix to the Petition for Writ of Certiorari:

Court of Appeals Opinion (March 22, 2012) . . . . . Pet. App. 1a

District Court Memorandum and Order (June 28, 2010) . . . . . Pet. App. 71a

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DOCKET ENTRIES

5:07-cv-00037-RLV, United States District Court, Western District of North Carolina

Date Filed	#	Docket Text
		* * * *
03/23/2007	2	COMPLAINT
		* * * *
04/13/2007	7	MOTION to Dismiss for Lack of Jurisdiction
		* * * *
04/23/2008		ORAL ORDER re 7 MOTION to Dismiss for Lack of Jurisdiction. Defendant's motion to dismiss pursuant to 12(b)(1) is denied. Defendant's [partial] motion to dismiss pursuant to Rule 12(b)(6) is granted. Plaintiff's claim alleging a violation of the Equal Protection Clause of the Fourteenth Amendment of the U.S. Constitution is dismissed without prejudice.

04/23/2008 (cont.)		This matter will be stayed for purposes of Rule 16 discovery obligations pending disposition in the North Carolina Supreme Court of the Andrews v. Haygood appeal. The parties shall notify the court within ten days of disposition of Andrews.
		* * * *
05/01/2008	12	ANSWER to 2 Complaint *Affirmative Defense*, COUNTERCLAIM *and Motion to Dismiss* against E.M.A.
		* * * *
01/28/2009	14	NOTICE *of Substitution of Defendant*
06/01/2009	15	ORDER LIFTING STAY and directing parties to file Certificate of Initial Atty's Conf. on or before 6/15/2009.
		* * * *

E.M.A. v. Cansler, Secretary of NC DHHS -
Relevant Docket Entries

06/25/2009	17	Consent MOTION to Amend/ Correct *Complaint* (Attachments #1 Memorandum In support of joint motion to add parties, #2 Exhibit Proposed Amended Complaint, #3 Proposed Order Amending Complaint
07/06/2009	18	ORDER granting 17 Motion to Amend/Correct Complaint to add Parties
07/06/2009	19	AMENDED COMPLAINT
07/10/2009	20	ANSWER to 19 Amended Complaint, COUNTERCLAIM against all plaintiffs
08/11/2009	21	Pretrial Order and Case Management Plan
09/30/2009	22	Consent MOTION TO Substitute Party *Guardian ad Litem*
		* * * *
10/02/2009	24	ORDER granting 22 Motion to Substitute Party
10/15/2009	25	MOTION for Summary Judgment

10/15/2009	26	AFFIDAVIT re 25 MOTION for Summary Judgment (Attachments: #1 Index to Exhibits, #2 Exhibit A, #3 Exhibit B, #4 Exhibit C, #5 Exhibit D, #6 Exhibit E, #7 Exhibit F, #8 Exhibit G)
		* * * *
10/15/2009	28	MOTION for Summary Judgment (Attachments: #1 Exhibit Index, #2 Exhibit C - G.S. § 108A-57, #3 Exhibit D - G.S. § 108A-59) (Additional attachment(s) added on 10/15/2009: #4 Exhibit A, #5 Exhibit B)
10/15/2009	29	MEMORANDUM in Support re 28 MOTION for Summary Judgment by [Defendant].
11/02/2009	30	MEMORANDUM in Opposition re 25 MOTION for Summary Judgment *Defendant's Response in Opposition to Plaintiffs' Motion for Summary Judgment* by [Defendant].

E.M.A. v. Cansler, Secretary of NC DHHS -
Relevant Docket Entries

11/02/2009	31	RESPONSE in Opposition re 28 MOTION for Summary Judgment by [Plaintiffs].
11/09/2009	32	REPLY to Response to Motion re 28 MOTION for Summary Judgment *Reply to Plaintiffs' Response to Defendant's Motion for Summary Judgment* by [Defendant].
11/16/2009	33	REPLY to Response to Motion re 25 MOTION for Summary Judgment by [Plaintiffs]
06/28/2010	34	ORDER denying plf's 25 Motion for Summary Judgment; granting dft's 28 Motion for Summary Judgment. Accordingly plf's cause of action is dismissed with prejudice.
06/28/2010	35	CLERK'S JUDGMENT
07/28/2010	36	NOTICE OF APPEAL
07/28/2010	37	Transmission of Notice of Appeal to US Court of Appeals re 36 Notice of Appeal.
07/29/2010	38	USCA case Number 10-1865 for 36 Notice of Appeal.

03/22/2012	39	Published Opinion from Fourth Circuit Court of Appeals, 4th Circuit decision - Vacated and Remanded.
04/13/2012	40	MANDATE of United States Court of Appeals.

* * * *

10-1865, Fourth Circuit Court of Appeals

07/29/2010	1	Case docketed.

* * * *

07/29/2010	3	DOCKETING NOTICE issued.

* * * *

08/11/2010	14	DOCKETING STATEMENT filed.

* * * *

10/26/2011	33	ORAL ARGUMENT
03/22/2012	34	PUBLISHED OPINION
03/22/2012	35	Judgment Order filed. Decision: Vacated and remanded.

* * * *

04/13/2012	37	Mandate issued.

* * * *

04/24/2012	39	ORDER filed denying Motion for costs [36]; denying bill of costs.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT
OF NORTH CAROLINA
CASE NO.: 5:07-cv-00037

EMILY M. ARMSTRONG, a minor By and Through Her Guardian ad Litem, STEPHANIE J. GIBBS, WILLIAM EARL ARMSTRONG and SANDRA ARMSTRONG

Plaintiffs,

v.

LANIER M. CANSLER, in his official capacity as secretary of the North Carolina Department of Health and Human Services

Defendant

[PROPOSED] AMENDED COMPLAINT (Declaratory Judgment Action)

NOW COME Plaintiffs, complaining of Defendant, and allege and say as follows:

INTRODUCTORY STATEMENT

1. This is a civil rights action brought pursuant to 42 U.S.C. §1983 seeking declaratory and injunctive relief as a result of the deprivation of the minor Plaintiff's rights as secured by 42 U.S.C. §1396p (known as the "Federal Medicaid Anti-Lien Provision") and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

2. In particular, Defendant Lanier M. Cansler, in his official capacity as Secretary of the North Carolina Department of Health and Human Services ("Defendant DHHS") has asserted a lien upon the proceeds arising from the minor Plaintiff's personal injury action against Defendants James A. Barnes, Jr., M.D., Newton Women's Care, P.A.; and Catawba Valley Medical Center.

3. Defendant DHHS's assertion of a lien under the circumstances of this case violates 42 U.S.C. §1396p and denies the minor Plaintiff equal protection under the law.

4. Plaintiffs seek a judgment declaring that Defendant DHHS does not have a lien on the proceeds arising from a personal injury action filed by the minor

and her parents against Defendants James A. Barnes, Jr., M.D., Newton Women's Care, P.A. and Catawba Valley Medical Center, or in the alternative, determining the amount of the lien Defendant DHHS has on the proceeds. Plaintiffs also seek a judgment declaring that North Carolina General Statutes §108A-57 and §108A-59 are unconstitutional under the Supremacy Clause in Article VI of the United States Constitution to the extent that they allow Defendant DHHS to assert a lien on compensation for damages other than medical expenses in violation of 42 U.S.C. §1396a, 42 U.S.C. §1396k, and 42 U.S.C. 1396p.

5. Finally, Plaintiffs seek a judgment enjoining Defendant DHHS from asserting a lien on the proceeds of the personal injury action and from enforcing North Carolina General Statutes §108A-57 and §108A-59 in a manner that violates 42 U.S.C. §1396, *et seq.*, *Arkansas Dep't of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (May 1, 2006) (hereinafter referred to as "*Ahlborn*"), and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

JURISDICTION AND VENUE

6. Plaintiffs' case arises under the laws and Constitution of the United States, specifically, 42 U.S.C. §1396a, 42 U.S.C. §1396k, 42 U.S.C. §1396p, the Supremacy Clause in Article VI of the Constitution, and the Equal Protection Clause of the Fourteenth Amendment.

7. This court has jurisdiction over Plaintiffs' claims under 28 U.S.C. §1331, 28 U.S.C. §1343(3), and 28 U.S.C. §1343(4).

8. Plaintiffs' lawsuit is authorized by 42 U.S.C. §1983 and 28 U.S.C. §2201.

9. Plaintiffs Emily M. Armstrong, William Earl Armstrong and Sandra Armstrong all reside in Alexander County. All of the events giving rise to this civil action occurred in Catawba County.

10. Under 28 U.S.C. §1391, venue is proper in the United States District Court for the Western District of North Carolina.

PARTIES

11. Emily M. Armstrong (hereinafter referred to as the minor Plaintiff) was born in 2000 and she is presently seven (7) years old. She resides in Alexander County with her parents, William Earl and Sandra Armstrong.

12. Stephanie J. Gibbs is a North Carolina attorney who has been appointed as the minor's Guardian ad Litem for the purposes of this litigation.

13. Stephanie J. Gibbs served as the guardian *ad litem* for the minor Plaintiff in the case of Emily M. Armstrong, by and through her guardian ad litem Stephanie Gibbs, et. al, v. James A. Barnes. Jr., M.D., Newton Women's Care, P.A.; and Catawba Valley Medical Center, Inc., 03 CvS 525, filed in Catawba County, having been duly appointed by the Senior Resident Superior Court Judge of Catawba County.

14. Defendant Lanier M. Cansler is sued in his official capacity as the Secretary of the North Carolina Department of Health and Human Services.

15. Defendant DHHS is an agency of the State of North Carolina, established pursuant to North Carolina General Statute §143B-136.1.

16. The North Carolina Division of Medical Assistance is a division of Defendant DHHS, established pursuant to G.S. §108A-54.

17. Defendant DHHS, by and through its Division of Medical Assistance, is responsible for administering and enforcing North Carolina's Medicaid program in accordance with 42 U.S.C. §1396, *et seq*.

18. Defendant DHHS is responsible for administering and enforcing liens or other rights of recovery which may arise by reason of a medical payment made to or on behalf of a Medicaid beneficiary in accordance with 42 U.S.C. §1396a, 42 U.S.C. §1396k, and 42 U.S.C. §1396p.

19. At all times relevant to this civil action, North Carolina's Medicaid program received funding from the United States government and Defendant DHHS was required to administer the program in accordance with federal law.

20. At all times relevant to this civil action, the minor Plaintiff was a Medicaid beneficiary and received medical assistance from Defendant DHHS.

FACTUAL ALLEGATIONS

21. Plaintiff Emily M. Armstrong, was born on February 25, 2000, in Catawba County, North Carolina.

22. At her birth, Emily M. Armstrong received severe injuries. The minor plaintiff has been diagnosed with cerebral palsy. She cannot sit, crawl, walk or talk. She is fed through a tube in her stomach. She receives physical, occupational and speech therapies and has seen specialists in the areas of pediatrics, neurology, gastroenterology, otolaryngology and orthopedics. She receives oxygen in the home and has to be suctioned frequently. She requires skilled nursing care and currently has nurses for 16-20 hours a day.

23. The minor Plaintiff received medical treatment for her injuries from a variety of healthcare providers, resulting in payments by Defendant DHHS in the amount of $1,945,009.67.

24. All of the payments by Defendant DHHS, as alleged in the preceding paragraph, were for the costs of the minor Plaintiff's medical care as a result of the injuries she suffered at her birth.

25. Under North Carolina law, two separate claims arose as a result of the injuries Emily M. Armstrong suffered: (1) The minor's parents, William Earl and Sandra Armstrong, were entitled to pursue a cause of action to recover the costs arising from the minor Plaintiff's medical care, education and other needs, along with a claim for severe emotional distress; and (2) the minor Plaintiff was entitled to pursue a cause of action, through her guardian *ad litem*, to recover her damages for pain and suffering, scarring, and permanent injury.

26. Under North Carolina law, the minor Plaintiff was not authorized to pursue a claim for medical expenses incurred prior to the age of 18, unless her parents waived or assigned that claim to her.

27. The minor's parents have never waived or assigned their claim for medical expenses to the minor Plaintiff or to her guardian *ad litem*.

28. On February 21, 2003, the minor plaintiff, through her guardian *ad litem*, and her parents filed a Complaint for negligence against Defendants James A. Barnes, Jr., MD., Newton Women's Care, P.A. and Catawba Valley Medical Center in the Superior Court of Catawba County, North Carolina file number 03 CvS 525.

29. In the Complaint, Emily M. Armstrong's guardian ad litem asserted, on behalf of the minor Plaintiff, claims for extreme mental and physical pain and suffering, permanent injuries and disfigurement and loss of the normal use of her body, along with claims for lost wages.

30. In the Complaint, the minor's parents asserted a claim for medical expenses, and Sandra Armstrong asserted a claim for negligent infliction of emotional distress.

31. On or about September 13, 2006, Defendant DHHS was notified by letter from the Plaintiffs pursuant to Rule 4B of the Rules for Mediated Settlement Conferences that a mediated settlement conference in the case was scheduled to take place September 27, 2006, and asking DHHS to send a representative to attend the conference.

32. A mediated settlement conference was held September 27, 2006. No representative from defendant DHHS attended.

33. On October 27, 2006, Defendant DHHS was notified by letter and a notice of hearing from the Plaintiffs that a hearing and motion for approval of the minor's settlement was scheduled for November 13, 2006.

34. A hearing was held November 13, 2006, in Catawba County Superior Court, at which time The Honorable Timothy A. Kincaid approved the settlement and ordered plaintiffs to dismiss the case against the defendants once their financial obligations were complete. No representative from defendant DHHS attended the hearing.

35. As part of approval of the settlement, Judge Kincaid ordered that the sum of $933,333.33, which he determined was the maximum amount DHHS could seek to recover under N.C. Gen. Stat. § 108A-57, be paid into the Catawba County Clerk of Court's office.

36. Defendant DHHS has informed plaintiffs that it believes it is entitled to all of the funds on deposit in the Catawba County Clerk of Court's office.

37. Defendant DHHS has improperly asserted a lien upon all of the minor Plaintiff's rights of recovery.

38. Defendant DHHS has continued to insist that it will not compromise or abandon its purported lien despite the U.S. Supreme Court holding in *Arkansas Dep't of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (May 1, 2006), which determined that Medicaid liens in personal injury actions may be asserted only for that portion of the settlement that is for medical bills, and cannot include portions of the plaintiffs' funds that are compensation for personal injuries.

39. On or about July 3, 2006, defendant DHHS received a memorandum from the U.S. Department of Health and Human Services' Center for Medicare and Medicaid Services (CMS) titled "State Options for Recovery Against Liability Settlement in Light of U.S. Supreme Court Decision in Arkansas Department of Human Services v. Ahlborn."

40. That memorandum stated: "Prior to the Supreme Court's decision in *Ahlborn*, CMS had interpreted the Medicaid third party liability provisions to authorize States to pass laws permitting full recovery of Medicaid assistance payments from

third party liability settlements, regardless of how the parties allocated the settlement. The Supreme Court rejected this interpretation of the Medicaid statute and held that to the extent State laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws."

41. The memorandum also stated: "A State's lien laws may only operate to recover from that portion of a settlement that is allocated to healthcare items or services, even if it means that Medicaid must forego full recovery of its claim."

42. Defendant DHHS has verbally informed Plaintiffs that its claim for subrogation needed to be paid in full from the settlement proceeds.

43. On December 12, 2006, in accordance with the order of Judge Timothy S. Kincaid, plaintiffs dismissed the lawsuit 03 CvS 525 filed in Catawba County Superior Court.

44. On or about December 29, 2006, despite the fact that the case had been dismissed, Defendant DHHS filed a Motion to Intervene in Catawba County file number 03 CvS 525, claiming that it was entitled to all

of the funds placed in escrow in the Catawba County Clerk of Court's office.

45. Plaintiffs disagree with Defendant DHHS's position that it is subrogated to, or has been assigned, any of the minor Plaintiff's rights of recovery in Catawba County file number 06 CVS 125 since the minor Plaintiff has no claim for medical expenses incurred prior to age 18 and Defendant's claim is therefore barred by federal law.

46. In particular, Defendant DHHS is asserting a lien (denominated as a "right of subrogation" or an "assignment") on the minor Plaintiff's settlement proceeds in a manner that violates 42 U.S.C. §1396p, the U.S. Supreme Court's decision in *Ahlborn*, and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

47. An actual and justifiable controversy exists between the parties as to whether Defendant DHHS is entitled to a lien on the proceeds arising from the minor Plaintiff's personal injury action.

FIRST CLAIM FOR RELIEF: DECLARATORY ACTION TO DETERMINE WHETHER DEFENDANT DHHS HAS A LIEN ON THE PROCEEDS ARISING FROM THE MINOR PLAINTIFF'S PERSONAL INJURY ACTION

48. Plaintiffs incorporate paragraphs 1 through 47 of this Complaint as if fully set out herein.

49. Defendant DHHS has asserted a lien on the proceeds arising from the minor Plaintiff's personal injury action against Defendants James A. Barnes Jr., M.D., Newton Women's Care, P.A. and Catawba Valley Medical Center.

50. 42 U.S.C. §1396, *et seq.* does not authorize Defendant DHHS to assert a lien on the total amount of these proceeds because most of the funds paid to the minor compensated her for the extensive injuries she received.

51. By asserting a lien on the proceeds from the minor Plaintiff's personal injury action, Defendant DHHS has deprived the minor Plaintiff of her rights under 42 U.S.C. §1396p and under the Equal Protection Clause of the Fourteenth Amendment.

52. Plaintiffs request that the Court issue a judgment which declares that Defendant DHHS does not have a lien on the proceeds from the minor Plaintiff's personal injury action, or in the alternative a judgment that determines the proper amount of the lien.

SECOND CLAIM FOR RELIEF: DECLARATORY ACTION TO DETERMINE WHETHER G.S. §108A-57 AND §108A-59 ARE CONSTITUTIONAL UNDER FEDERAL LAW

53. Plaintiffs incorporate paragraphs 1 through 52 of this Complaint as if fully set out herein.

54. Defendant DHHS has asserted a lien on the proceeds of the underlying medical malpractice action under G.S. §108A-57 and §108A-59.

55. On their face, G.S. §108A-57 and §108A-59 allow Defendant DHHS to impose a lien (denominated in the statutes as a "right of subrogation" and an "assignment" respectively) on all compensation received by the minor Plaintiff, even those proceeds that are paid for the many injuries she received.

56. G.S. §108A-57 and §108A-59 are unconstitutional under the Supremacy Clause of the United States Constitution to the extent that they allow Defendant DHHS to assert a lien on compensation for damages other than medical expenses in violation of 42 U.S.C. §1396a, 42 U.S.C. §1396k, and 42 U.S.C. §1396p.

57. Plaintiffs request that the Court issue a judgment which declares G.S. §108A-57 and §108A-59 unconstitutional under the Supremacy Clause to the extent that these statutes allow Defendant DHHS to impose a lien on compensation for damages other than medical expenses.

THIRD CLAIM FOR RELIEF:
INJUNCTION AGAINST DEFENDANT DHHS

58. Plaintiffs incorporate paragraphs 1 through 57 of this Complaint as if fully set out herein.

59. On May 1, 2006, the United States Supreme Court issued its decision in *Alhborn*.

60. On or about May 26, 2006, the U.S. Supreme Court's mandate in *Ahlborn* was issued.

61. Since May 26, 2006, Defendant DHHS has engaged in an ongoing and continuing violation of Federal law by claiming that it has a lien, under G.S. §108A-57 and §108A-59, on the personal injury action even though the substantial amount of plaintiff Emily Armstrong's recovery was based on the injuries she received, and none of the payment to the minor was for medical expenses already incurred.

62. Upon the issuance of a declaration that G.S. §108A-57 and §108A-59 are unconstitutional to the extent that they allow Defendant DHHS to assert a lien on proceeds for damages other than medical expenses, Plaintiffs request that the Court enjoin Defendant DHHS from imposing a lien on the minor Plaintiff's proceeds and from enforcing these statutes in a manner that violates 42 U.S.C. §1396, *et seq.*, *Ahlborn*, and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray the Court for the following relief:

1. A judgment declaring that Defendant DHHS does not have a lien on the proceeds from the minor Plaintiff's personal injury action now held in the Catawba County Clerk's office, and determining the limit of any lien against the parents' proceeds.

2. A judgment declaring that G.S. §108A-57 and §108A-59 are unconstitutional under the Supremacy Clause of the United States Constitution to the extent that these statutes allow Defendant DHHS to impose a lien on compensation for damages other than medical expenses in violation of 42 U.S.C. §1396a, 42 U.S.C. §1396k, and 42 U.S.C. §1396p.

3. A judgment enjoining Defendant DHHS from imposing a lien on the proceeds from the Plaintiffs' personal injury action and from enforcing G.S. §108A-57 and §108A-59 in a manner that violates federal law;

4. An order that the Clerk of Court of Catawba County pay the entire sum held out of the proceeds of Emily M. Armstrong's settlement to The Emily M. Armstrong Irrevocable Special Needs Trust; or such portions as the court deems proper under federal law;

5. That Plaintiffs have and recover their costs of court, including a reasonable attorney's fee, from Defendant DHHS;

6. That all issues of fact be tried by a jury; and

7. For such other and further relief as may be deemed just and proper.

This the 25th day of June, 2009.

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[Certificate of Service omitted in printing]

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NORTH CAROLINA
STATESVILLE DIVISION
CASE NO. 5:07-CV-37-RLV

EMILY M. ARMSTRONG, a Minor by and Through Her Guardian ad Litem, STEPHANIE J. GIBBS, WILLIAM EARL ARMSTRONG AND SANDRA ARMSTRONG,

Plaintiffs,

v.

LANIER CANSLER, in his official capacity as secretary of the North Carolina Department of Health and Human Services,

Defendant.

ANSWER TO AMENDED COMPLAINT Fed. R. Civ. P. 7(a)(2)

NOW COMES Defendant, and in answer to Plaintiffs' Amended Complaint, says and avers as follows:

FIRST DEFENSE: ESTOPPEL

The Plaintiffs' claims are barred, in whole or in part, by the doctrine of estoppel. In the original State Court

proceeding Plaintiffs asked the State Court to escrow these funds representing the "maximum potential lien amount." *See* Order of Judge Thomas Kincaid, Catawba County file number 03 CVS 525, entered November 14, 2006. The State Court escrowed the funds as requested. Now the Plaintiffs have changed their position and assert that none of the funds escrowed can be recovered by DHHS because they do not represent medical damages. This position is clearly inconsistent with the position Plaintiffs took before the State Court when requesting that these funds be escrowed.

SECOND DEFENSE: ABSTENTION

The Court should abstain from deciding the State common law question of whether a Medicaid eligible child has a claim for medical damages. Plaintiffs allege the minor Plaintiff has no claim for medical damages under North Carolina common law. Defendant denies the relevance of the common law to the application of the federal and State Medicaid statutes. To the extent there is any question about the role of the common law in this matter, the Court should abstain and allow the State courts to review the issue so as to avoid unnecessary federal interference in State operations.

COUNTERCLAIM

1. The Court has jurisdiction of this Counterclaim under 28 U.S.C. § 1367(a) because it arises out of the same transaction and occurrence alleged in the Plaintiffs' amended complaint so as to form a part of the same case or controversy within the meaning of Article III of the United States Constitution.

2. On April 26, 2000, Plaintiff Sandra Armstrong applied for Medicaid coverage for Plaintiff Emily Armstrong and agreed "to give back to the State any and all money that is received by me or anyone listed on this application from any insurance company for payment of medical and/or hospital bills for which the Medical Assistance program has or will make payment. In addition, I agree that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the State to repay past or current medical expenses paid by the State. This includes insurance settlements resulting from an accident. I further agree to notify the county department of social services if I or anyone listed on this application is involved in any accident."

3. Plaintiffs sued for medical negligence and recovered medical damages.

4. DHHS paid over one-third the gross amount of the settlement received for medical care related to the negligence.

5. Pursuant to N.C. Gen. Stat. §§ 108A-57 and 108A-59, Plaintiffs owe DHHS one-third the gross amount of the settlement they received.

ANSWER

1. Paragraph 1 of the Amended Complaint is denied. It is denied that the minor Plaintiff has suffered a deprivation of her rights.

2. Paragraph 2 is denied. It is denied that DHHS is asserting a lien on only the "proceeds arising from the minor Plaintiff's personal injury action." DHHS has asserted a lien on one-third of the entire settlement which the minor child and her parents together received in the state court medical negligence action Catawba County 03 CVS 525, *Emily M. Armstrong, By and Through Her Guardian ad Litem Stephanie Gibbs, and Sandra Armstrong and William Armstrong v. James A. Barnes, Jr., M.D., Newton Women's Care, P.A.; Catawba Memorial Hospital, Inc., and Catawba Valley Medical Center, Inc.* One-third of the entire settlement received by both the parents and child together was escrowed.

3. Paragraph 3 is denied.

4. Paragraph 4 is denied.

5. Paragraph 5 is denied.

6. Paragraph 6 is denied to the extent it conflicts with this Court's Order of April 22, 2008 setting forth the basis of this Court's jurisdiction.

7. Paragraph 7 is denied to the extent it conflicts with this Court's Order of April 22, 2008 setting forth the basis of this Court's jurisdiction.

8. Paragraph 8 is denied to the extent it conflicts with this Court's Order of April 22, 2008 setting forth the basis of this Court's jurisdiction.

9. Paragraph 9 is admitted upon information and belief.

10. Paragraph 10 is admitted.

11. Paragraph 11 is admitted upon information and belief.

12. Paragraph 12 is admitted.

13. Paragraph 13 is admitted.

14. Paragraph 14 is admitted.

15. Paragraph 15 is admitted.

16. Paragraph 16 is admitted.

17. Paragraph 17 is admitted.

18. Paragraph 18 is admitted.

19. Paragraph 19 is admitted.

20. Paragraph 20 is admitted.

21. Paragraph 21 is admitted upon information and belief.

22. Paragraph 22 is admitted upon information and belief.

23. Paragraph 23 is admitted, except that the exact sums paid by DHHS, Division of Medical Assistance for the Plaintiff's care as of the date of the settlement was $1,903,004.37.

24. Paragraph 24 is admitted.

25. Paragraph 25 is denied.

26. Paragraph 26 is denied.

27. Paragraph 27 is denied. Upon information and belief, Plaintiffs Sandra and William Armstrong, the minor Plaintiff's parents, applied for her eligibility for Medicaid and at that time they would have assigned

all rights to medical recovery from third parties to the State as a statutory condition of eligibility pursuant to N.C. Gen. Stat. § 108A-59. The Plaintiff would have this Court believe there is a loophole whereby the State can never recover the medical damages paid on behalf of a Medicaid recipient child. There is no loophole. *See Ezell v. Grace Hospital*, 360 N.C. 529, 631 S.E.2d 131 (2006) *and Andrews v. Haygood*, 188 N.C. App. 244, 655 S.E.2d 440 (2008), *aff'd by, review improvidently allowed by, in part* 362 N.C. 599, 669 S.E.2d 310, *cert. denied Brown v. N.C. HHS*, 2009 U.S. LEXIS 4519, 77 U.S.L.W. 3678 (U.S. June 15, 2009); *see also* 42 C.F.R. 433.145(a)(1): "A State Plan must provide that, as a condition of eligibility, each legally able applicant or recipient is required to: Assign to the Medicaid agency his or her rights, or the rights of any other individual eligible under the plan for whom he or she can legally make an assignment, to medical support and to payment for medical care from any third party[.]"

28. Paragraph 28 is admitted.

29. Paragraph 29 is admitted to the limited extent it is admitted that the Amended Complaint set forth the minor Plaintiff's claims as listed; it is denied that the State is prevented simply by the parties' manner of pleading from recovering its medical expenses.

30. Paragraph 30 is admitted to the limited extent it is admitted that the Amended Complaint set forth

the parents' claims as listed; it is denied that the State is prevented simply by the parties' manner of pleading from recovering its medical expenses.

31. Paragraph 31 is denied. It is denied that DHHS was put on notice. A letter concerning the mediated settlement conference was sent by plaintiffs' attorneys to the case worker for DMA, not the registered agent for service of legal process pursuant to N.C. Gen. Stat. § 1A-1, Rule 4. By contrast, when the plaintiffs' attorneys filed the instant action, they notified the registered agent for DHHS.

32. Paragraph 32 is admitted upon information and belief.

33. Paragraph 33 is denied. It is denied that DHHS was put on notice. Again, plaintiffs' attorneys notified the case worker, not the registered agent for DHHS.

34. Paragraph 34 is admitted.

35. Paragraph 35 is admitted.

36. Paragraph 36 is admitted.

37. Paragraph 37 is denied.

38. Paragraph 38 is admitted. DHHS has a statutory lien on the escrowed funds that is not

inconsistent with the United States Supreme Court's holding in *Ahlborn*.

39. Paragraph 39 is admitted.

40. Paragraph 40 is admitted upon information and belief.

41. Paragraph 41 is admitted upon information and belief.

42. Paragraph 42 is admitted. It is denied that DHHS is asserting a lien on only the minor Plaintiff's settlement proceeds. DHHS asserts a lien on one-third of the full settlement recovered by the minor child and her parents together. The funds cannot be labeled so as to defeat DHHS's statutory recovery.

43. Paragraph 43 is admitted.

44. Paragraph 44 is admitted.

45. Paragraph 45 is denied. DHHS's claim is not barred by federal law (*see* 42 C.F.R. 433.145(a)(1)) DHHS has the right to recover the medical expenses paid by the State from the medical negligence settlement recovered by the parents and the child together.

46. Paragraph 46 is denied.

47. Paragraph 47 is admitted only to the extent it is admitted that a justiciable controversy exists among the minor Plaintiff, and her parents, and DHHS as to the amount of the State's lien on the settlement recovered by the minor Plaintiff and her parents; otherwise Paragraph 47 is denied.

48. DHHS incorporates each and every admission, denial, and averment made by DHHS in Paragraphs 1 through 47 of this Answer to allegations in Paragraphs 1 through 47 of the Amended Complaint as if fully set forth.

49. Paragraph 49 is denied. DHHS is asserting a lien on the proceeds arising from the Plaintiffs' negligence action.

50. Paragraph 50 is denied.

51. Paragraph 51 is denied.

52. Paragraph 52 is denied.

53. DHHS incorporates each and every admission, denial, and averment made by DHHS in Paragraphs 1 through 52 of this Answer to allegations in Paragraphs 1 through 52 of the Amended Complaint as if fully set forth.

54. Paragraph 54 is denied. DHHS is asserting a lien on the proceeds arising from the Plaintiffs' negligence action for medical damages.

55. Paragraph 55 is denied.

56. Paragraph 56 is denied.

57. Paragraph 57 is denied.

58. DHHS incorporates each and every admission, denial, and averment made by DHHS in Paragraphs 1 through 57 of this Answer to allegations in Paragraphs 1 through 57 of the Amended Complaint as if fully set forth.

59. Paragraph 59 is admitted.

60. Paragraph 60 is admitted.

61. Paragraph 61 is denied.

62. Paragraph 62 is denied.

PRAYER FOR RELIEF

WHEREFORE, Defendant respectfully prays:

1. That this Court deny all the relief requested by Plaintiffs;

2. That this Court abstain from ruling on the State common law question of whether a Medicaid eligible child has a claim for medical damages;

3. That the clerk of Court of Catawba County be ordered to pay Defendant the entire sum of the escrowed proceeds from the settlement recovered by the minor child and her parents together;

4. That the costs of this action be taxed against the Plaintiffs, including a reasonable attorney's fee; and

5. For all such further relief as this Court may deem just and proper.

Respectfully submitted, this the 10th day of July, 2009.

ROY COOPER
Attorney General

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[Certificate of Service omitted in printing]

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT
OF NORTH CAROLINA
CIVIL ACTION NO.: 5:07-cv-00037

EMILY M. ARMSTRONG, a minor
By and Through Her Guardian Ad
Litem, WILLIAM W. PLYER,
WILLIAM EARL ARMSTRONG and
SANDRA ARMSTRONG

Plaintiffs,

v.

LANIER M. CANSLER. in his official capacity as secretary of the North Carolina Department of Health and Human Services

Defendant

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

ORAL ARGUMENT REQUESTED

Now come plaintiffs Emily Armstrong, by and though her guardian *ad litem*; William W. Plyler, Sandra Armstrong and William Armstrong, and move this court, with supporting affidavits, pursuant to F. R. Civ. Pro. 56, to grant summary judgment to the plaintiffs, finding that North Carolina General Statutes §108A-57 and §108A-59 are unconstitutional under the Supremacy Clause in Article VI of the

United States Constitution to the extent that they allow the N.C. Department of Health and Human Services to assert a lien on compensation for damages other than medical expenses in violation of 42 U.S.C. §1396a, 42 U.S.C. §1396k, and 42 U.S.C. 1396p. Plaintiffs further ask that the court order an evidentiary hearing to determine the proper amount of the lien in this matter.

Plaintiffs further show the court as follows:

1. This claim arises out of an assertion by the State of North Carolina that it has a lien for one-third of the total proceeds of a tort recovery received by Emily Armstrong, a 9-year-old girl suffering from cerebral palsy, and her parents.

2. Emily Armstrong, through her guardian ad litem, filed an underlying tort complaint in state court, stating that she suffered cerebral palsy as a result of injuries she suffered at her birth caused by the negligence of the doctor who delivered her and the hospital personnel. As a result of those injuries, Emily cannot sit, crawl, walk or talk. Emily receives skilled nursing care that is paid for by the Medicaid program.

3. As part of Emily's settlement of the tort claim, Defendant DHHS was notified of the hearing for approval of the minor's settlement. On November 13, 2006, a hearing was held and the settlement was

approved. The DHHS attorneys did not attend the hearing.

4. At that hearing, Superior Court Judge Timothy S. Kincaid determined the maximum amount that DHHS could seek to recover as its lien and ordered that amount paid into the Catawba County Clerk of Court's office until the proper amount of the lien could be determined.

5. On March 22, 2007, Emily Armstrong filed a claim in U.S. District Court, Western District of North Carolina, under 42 U.S.C. § 1983, seeking declaratory and injunctive relief and claiming that the State of North Carolina is violating 42 U.S.C. § 1396p, the federal Medicaid anti-lien statute, and is in violation of the Supremacy Clause of the Constitution of the United States by insisting it is entitled to one-third of the settlement that went to Emily Armstrong and her parents. In their lawsuit, plaintiffs sought to have the federal court determine the proper amount of the funds held in the Catawba County Clerk of Court's office that should be allocated to Medicaid's lien.

6. On September 24, 2007, more than six months after Emily Armstrong filed suit in U.S. District Court, the State of North Carolina filed suit against Emily Armstrong and her parents in state court, asking the state court to award it all of the money held in the Catawba County Clerk's office.

7. In May, 2006, a U.S. Supreme Court decision, *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006), determined that federal law prohibits states from taking a larger portion of a Medicaid patient's settlement than the proportionate amount of the settlement that can properly be attributed to past medical payments.

8. Emily Armstrong did not receive any funds for past medical expenses through the settlement, because such a recovery belongs to her parents under North Carolina law. Plaintiffs believe the State's recovery must be limited to a portion of the funds received by Emily's parents, and cannot include taking funds from Emily herself, because those funds did not include any compensation for past medical expenses.

Therefore, plaintiffs Emily Armstrong, by and though her guardian *ad litem*, William W. Plyer, Sandra Armstrong and William Armstrong, move this court to determine that the defendant is not entitled to fully one-third of the total settlement in the case, as it claims, and to order an evidentiary hearing regarding the proper amount of the lien.

This the 15th day of October, 2009.

KIRBY & HOLT, L.L.P.

/s/ C. Mark Holt
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[Certificate of Service omitted in printing]

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - AFFIDAVIT OF WILLIAM B. BYSTRYNSKI (filed Oct. 15, 2009)

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT
OF NORTH CAROLINA
CASE NO.: 5:07-CV-00037

EMILY M. ARMSTRONG, a minor By and Through Her Guardian ad Litem, WILLIAM W. PLYER, WILLIAM EARL ARMSTRONG and SANDRA ARMSTRONG

Plaintiffs,

v.

LANIER M. CANSLER, in his official capacity as secretary of the North Carolina Department of Health and Human Services

Defendant

AFFIDAVIT OF WILLIAM B. BYSTRYNSKI

William B. Bystrynski, first being duly sworn, deposes and says:

1. I am an attorney practicing law with the law firm of Kirby & Holt, LLP, in Raleigh, North Carolina.

2. I am one of the attorneys who represented Emily M. Armstrong in a case originally titled Emily Armstrong, by and through her guardian ad litem, G.

Bryan Collins Jr., *et al.* v. James A. Barnes Jr., M.D., *et al.*, 03 CvS 525, filed in Catawba County Superior Court in 2003.

3. Attached are true and correct copies of the following documents that were filed in that case:

a. Exhibit A: The complaint filed in the case.

b. Exhibit B. An order from Judge Timothy Kincaid, approving the settlement of that case.

4. Also attached are three affidavits:

a. Exhibit C. An affidavit of Cynthia Wilhelm, Ph. D, an expert in rehabilitation counseling, which includes her CV and the report she produced in the underlying tort case analyzing the lifetime needs of Emily Armstrong

b. Exhibit D. An affidavit of Finley Lee, Ph.D, an expert economics, which includes his CV and his report in the underlying tort case analyzing the economic needs of Emily Armstrong and her lost income.

c. Exhibit E. An affidavit from Sandra Armstrong, mother of Emily Armstrong

5. Also attached are two documents sent to the Department of Health and Human Services during the underlying tort case:

a. Exhibit F. A letter dated September 13, 2006, notifying the N.C. Department of Health and Human Services Division of Medical Assistance of the upcoming mediation in the underlying tort case.

b. Exhibit G. Notice of hearing dated October 27 2006, informing the Division of Medical Assistance that a court approval hearing for the minor's settlement was scheduled for November 13, 2006.

Further, affiant sayeth not.

This the 15th day of October, 2009.

KIRBY & HOLT, L.L.P.

/s/ William B. Bystrynski
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[Jurat and Certificate of Service omitted in printing]

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - AFFIDAVIT OF WILLIAM B. BYSTRYNSKI - INDEX OF EXHIBITS (filed Oct. 15, 2009)

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT
OF NORTH CAROLINA
CASE NO.: 5:07-CV-00037

EMILY M. ARMSTRONG, a minor by and through Her Guardian ad Litem, WILLIAM W. PLYER, WILLIAM EARL ARMSTRONG and SANDRA ARMSTRONG

Plaintiffs,

v.

LANIER M. CANSLER, in his official capacity as secretary of the North Carolina Department of Health and Human Services

Defendant

INDEX TO EXHIBITS

Exhibit A -- Complaint

Exhibit B -- Order Approving Settlement

Exhibit C -- Affidavit of Cynthia L. Wilhelm, Ph.D.

Exhibit D -- Affidavit of J. Finley Lee, Ph.D.

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - AFFIDAVIT OF WILLIAM B. BYSTRYNSKI - INDEX OF EXHIBITS
(filed Oct. 15, 2009)

Exhibit E -- Affidavit of Sandra Armstrong

Exhibit F -- Letter dated September 13, 2006, to the NC Department of Health and Human Services Division of Medical Assistance

Exhibit G -- Notice of Hearing

NORTH CAROLINA	IN THE GENERAL COURT OF JUSTICE
CATAWBA COUNTY	SUPERIOR COURT DIVISION 03 CvS 525

EMILY M. ARMSTRONG, By and Through Her Guardian ad Litem, G. BRYAN COLLINS, JR., and SANDRA ARMSTRONG and WILLIAM EARL ARMSTRONG,

Plaintiffs,

v.

JAMES A. BARNES, JR., M.D.; NEWTON WOMEN'S CARE, P.A.; CATAWBA MEMORIAL HOSPITAL, INC., and CATAWBA VALLEY MEDICAL CENTER, INC.,

Defendants.

COMPLAINT (Jury Trial Demanded)

Plaintiffs, complaining of the defendants, allege and say:

PARTIES

1. Plaintiff Emily M. Armstrong was born on February 25, 2000 in Catawba County, North Carolina. She appears in this action by and through her Guardian ad Litem, G. Bryan Collins, Jr., a citizen and resident of Wake County, North Carolina, who has been duly qualified and is acting as such Guardian ad Litem in the filing of this action. Emily resides in Alexander County, North Carolina, with her parents.

2. Plaintiffs Sandra Armstrong ("Mrs. Armstrong") and William Earl Armstrong ("Mr. Armstrong") are married and are the parents of Emily M. Armstrong They are citizens and residents of Taylorsville in Alexander County, North Carolina.

3. Upon information and belief, Defendant James A. Barnes, Jr., M.D. ("Dr. Barnes") is a citizen and resident of Catawba County, North Carolina. At all times relevant to this action, Dr. Barnes was a physician, obstetrician and gynecologist, licensed to practice medicine under the laws of the State of North Carolina and was practicing in Catawba County, North Carolina.

4. Upon information and belief, at all times relevant to this action, Dr. Barnes limited his practice of medicine to obstetrics and gynecology and held

himself out to be an expert and specialist in the field of obstetrics, having special knowledge and skill possessed by obstetricians in his locality or other similar localities with the same or similar training and experience.

5. Defendant Newton Women's Care, P.A., is a professional corporation duly organized and existing under the laws of the State of North Carolina, operating a medical practice offering services in obstetrics and gynecology, with its principal place of business in Newton, Catawba County, North Carolina.

6. At all times relevant herein, Dr. Barnes was acting as agent and/or employee of Newton Women's Care, P.A., and was acting within the course and scope of said employment and/or agency.

7. Defendant Newton Women's Care, P.A., is liable for any and all negligent acts and/or omissions of Dr. Barnes as set forth herein.

8. Defendant Catawba Memorial Hospital, Inc., ("the Hospital") is a North Carolina corporation organized and existing under the laws of the State of North Carolina with its registered and principal office located in Catawba County, North Carolina and at the time of these events operated a hospital providing medical services in Catawba County, North Carolina.

At the time of the events of this case, this hospital was doing business under the name of Catawba Memorial Hospital.

9. Defendant Catawba Valley Medical Center, Inc., ("the Hospital") is a North Carolina corporation organized and existing under the laws of the State of North Carolina with its registered and principal office located in Catawba County, North Carolina and operating a hospital providing medical services in Catawba County, North Carolina. Upon information and belief, Catawba Memorial Hospital, Inc., has changed its name to Catawba Valley Medical Center, Inc., or, alternatively, Catawba Valley Medical Center, Inc., has acquired all the assets and liabilities of Catawba Memorial Hospital, Inc., and is therefore responsible for the negligence of employees, agents and officers of Catawba Memorial Hospital at the time of these events.

10. Nurses, employees, servants and agents of the Hospital defendants were in control of the labor and delivery department and all rooms and other facilities of the hospital before, at the time of the arrival, and during the admission of Emily M. Armstrong on February 25, 2000, and before and at the birth of Emily M. Armstrong on February 25, 2000..

11. Nurses, employees, servants and agents of the Hospital defendants working in the labor and delivery areas were, at all times relevant to this action, agents and employees of the Hospital defendant and, as such, were acting within the course and scope of such agency and/or employment. Thus, the Hospital defendants are liable for any and all negligent acts and omissions of these nurses, employees, servants and agents as alleged more fully herein.

12. As of February 25, 2000, the Hospital defendants had extended privileges to Defendant Barnes to perform obstetrical services at their facility, including the laboring of patients and the performance of c-section deliveries.

THE NATURE OF THE CASE

13. Plaintiffs incorporate paragraphs 1 through 12 of this Complaint as if fully set out herein.

14. This action includes:

(a) a medical malpractice action as defined in North Carolina General Statutes §90-21.11 and Rule 26(fl) of the North Carolina Rules of Civil Procedure against Defendants James A. Barnes, Jr., M.D.; Newton Women's Care, P.A.; and Catawba Valley Medical Center, Inc.;

(b) a common law negligence action against the defendants, based upon common law theories of medical negligence and the principles of respondeat superior and agency; and

(c) a common law negligence action against the Hospital defendants and Newton Women's Care, P.A., based upon the principles of administrative and corporate responsibility.

FACTS

15. Plaintiffs incorporate paragraphs 1 through 14 of this Complaint as if fully set out herein.

16. On August 11, 1999, Sandra Armstrong began prenatal visits with James A. Barnes, Jr., M.D., at Newton Women's Care, P.A., in Newton, North Carolina. Mrs. Armstrong was given an estimated delivery date of March 18, 2000. This was her third pregnancy and she was 38 years old.

17. Mrs. Armstrong continued her prenatal care until her admission to Catawba Memorial Hospital on February 25, 2000, for a non-stress test. Her pregnancy was complicated by her age and by chronic hypertension. She was placed on a medication for the hypertension.

18. All of Mrs. Armstrong's prenatal labs were normal. Dr. Barnes notes that serial ultrasounds of the fetus were normal.

19. Mrs. Armstrong saw Dr. Barnes on February 22, 2000, when she was 36 weeks pregnant. Her blood pressure was slightly elevated at 136/92 and Dr. Barnes decided to start non-stress testing twice a week.

20. Upon information and belief, Dr. Barnes called the hospital to schedule the non-stress test (NST) but did not succeed in scheduling the test. Mrs. Armstrong was told to go home and she would be called regarding scheduling the test.

21. Upon information and belief, on February 25, 2000, at around 10:00 a.m., Mrs. Armstrong called the hospital to inquire about the non-stress test because she had not heard from either the hospital or Dr. Barnes. When asked if she had called before, Mrs. Armstrong informed the nurse that she had been told she would be called but that she had not heard from anyone. Mrs. Armstrong was told to eat lunch and then report to the hospital for the NST.

22. Despite these documented events, on his admission note for Mrs. Armstrong dated February 25, 2000, Dr. Barnes recorded that the patient had

received an NST the day before which was "not technically reactive but reassuring." He further stated that his decision to induce labor was made due to this test. There is no record of a non-stress test ever being performed on February 24, 2000, or any other time prior to February 25.

23. Mrs. Armstrong arrived at the hospital around 12:10 p.m. as instructed. She was placed on a fetal monitor for a non-stress test. The fetal heart rate baseline was 140 beats per minute with a drop in fetal heart rate with every fetal movement. The variability was minimal, which is a non-reassuring sign. The nurse noted variable decelerations to as low as the 60s. Despite these decelerations, the nurse removed the fetal heart rate monitor and allowed Mrs. Armstrong to get up to the bathroom.

24. At 1:20 p.m., the nurses called Dr. Barnes and he came to observe the strip. He performed a sterile vaginal exam and recorded that the cervix was closed, thick and hard. In a late entry by the nurse, it was noted that Mrs. Armstrong was crying and that Dr. Barnes discussed a plan of care and c-section. Upon information and belief, Dr. Barnes discussed the options for delivery with Mrs. Armstrong and a decision was made to proceed with a trial of labor induction using Pitocin.

25. Mrs. Armstrong was admitted to the hospital and Pitocin was started at 2:35 p.m. The fetal heart rate baseline was 150 with minimal to absent variability and variable decelerations. The Pitocin was turned off at 3:15 p.m and Dr. Barnes was notified. No other intrauterine resuscitative measures were performed.

26. Between 3:15 p.m. and 5:10 p.m., the fetal heart baseline was 150 with minimal to absent variability and variable decelerations. During this time, Mrs. Armstrong's blood pressure was elevated. Despite all of these non-reassuring signs, the nurse allowed Mrs. Armstrong out of the bed several times.

27. Dr. Barnes arrived at 5:10 p.m. and ordered the Pitocin to be restarted. Mrs. Armstrong was turned to her side and was given medication for her hypertension. The Pitocin was restarted. At 5:40 p.m., Mrs. Armstrong's blood pressure was elevated in a range from 202/116 to 182/103. Despite this finding and the non-reassuring fetal heart rate, the nurse continued to allow Mrs. Armstrong out of bed.

28. At 6:30 p.m., the Pitocin was increased. The fetal heart rate baseline was 140s with minimal variability and decelerations. Mrs. Armstrong was allowed to get out of the bed several times even with

this instability of her condition and the non-reassuring fetal heart rate.

29. At 7:00 p.m., the nurse again increased the Pitocin. The fetal heart rate remained non-reassuring and Mrs. Armstrong's blood pressure continued to be elevated.

30. At 7:25 p.m., the Pitocin was increased once again. Immediately following this increase, the fetal heart rate dropped to the 70s with a slow return to the baseline and then fell again to the 60s. In spite of this ominous pattern, the nurse removed the monitor and allowed Mrs. Armstrong to go to the bathroom.

31. At 7:38 p.m., when the monitor was reapplied, the fetal heart rate had fallen to 90 beats per minute. It gradually increased to 120 and then the tracing became illegible. Mrs. Armstrong was turned from side to side. The Pitocin was turned off at 7:42 p.m. The fetal heart rate at this time was 70 with absent variability. The fetal heart rate returned to 130 briefly and then decelerated to a bradycardia of 60.

32. Oxygen was administered to Mrs. Armstrong starting at 7:45 p.m. and she was put in knee-chest position. When Dr. Barnes arrived at 7:52 p.m. the fetal heart rate was 60-70 beats per minute. Dr. Barnes performed a sterile vaginal exam and then

notified the operating room personnel that he would be performing a Cesarean section.

33. Upon information and belief, the operating room normally used for Cesarean sections was in use at the time Dr. Barnes decided to proceed with a surgical delivery. Consequently, Mrs. Armstrong was taken to an overflow operating room at 7:59 p.m. During this time, there was no tracing of the fetal heart rate and Mrs. Armstrong's blood pressure remained elevated at 222/112.

34. Even at this time, no pediatrician was called and no other surgeon was called to help. Mrs. Armstrong was taken to the overflow operating room. Rather than being given general anesthesia for an emergency c-section, a spinal anesthetic was administered.

35. Emily Armstrong was born at 8:13 p.m. with no respirations or heart rate. Emily's Apgars were 0/0/4/4 at 1, 5, 10 and 15 minutes of life. According to Dr. Barnes' note, she had her cord around her neck four times.

36. Upon information and belief, no pediatrician or nurse practitioner had been called in advance regarding this delivery. Upon information and belief, a nurse practitioner was called in from the operating

room normally used for c-section deliveries in which another c-section was taking place. This nurse practitioner arrived after Emily's delivery and began care of Emily.

37. Upon information and belief, because Emily was delivered in a room that was rarely used for c-section operations, much of the equipment necessary to perform a rapid resuscitation - including oxygen, a warmer and emergency equipment - was not present in the room.

38. No pediatrician was called to attend to Emily until 8:15 p.m. She was intubated at 8:18 p.m. by the neonatal nurse practitioner, but was without a heart rate for the first eight minutes of life. The pediatrician arrived at 8:30 p.m.

39. Emily began having seizure activity within 2 hours after birth. Emily remained at Catawba Memorial Hospital in the Neonatal Intensive Care Unit until March 8, 2000, and then she was transferred to Brenner Children's Hospital in Winston-Salem where she remained until April 3, 2000. Emily was then sent home with her parents.

40. Emily lives in Taylorsville with her parents, William Earl and Sandra Armstrong, and Sandra's son and daughter. Emily is William Earl's only child.

Emily has been diagnosed with cerebral palsy. She cannot sit, craw, walk or talk. She is fed through a tube in her stomach. She receives physical, occupational and speech therapies and has seen specialists in the areas of pediatrics, neurology, gastroenterology, otolaryngology and orthopedics. She receives oxygen in the home and has to be suctioned frequently. Emily requires skilled nursing care and currently has nurses for 16- 20 hours a day.

41. The medical care identified herein has been reviewed by experts who are reasonably expected to qualify as experts under Rule 702 of the N.C. Rules of Evidence and who are willing to testify that the medical care identified herein did not comply with the applicable standard of care.

42. The damages described above are in excess of $10,000.

FIRST CAUSE OF ACTION
(Negligence of James A. Barnes, Jr., M.D., and Newton Women's Care, P.A.).

43. Plaintiffs incorporate paragraphs 1 through 42 of this Complaint as if fully set out herein.

44. Defendant Dr. Barnes was negligent in that he:

(a) failed to perform appropriate antenatal fetal surveillance on a high-risk patient;

(b) failed to appropriately assess and treat Mrs. Armstrong and Emily Armstrong;

(c) failed to recognize and react to a non-reassuring fetal monitor tracing;

(d) failed to remain with a patient with a non-reassuring fetal monitor pattern;

(e) failed to remain with a patient with unstable hypertension;

(f) failed to respond to signs and symptoms of fetal distress;

(g) failed to notify and assemble appropriate personnel and equipment for resuscitation of a depressed neonate;

(h) failed to use Pitocin in an appropriate manner;

(I) failed to discontinue Pitocin in response to non-reassuring fetal heart rate patterns;

(j) failed to deliver, in a timely manner, a baby showing signs of stress or distress;

(k) failed to assure that proper facilities were available for the care and treatment of a depressed neonate;

(1) failed to possess the degree of professional learning, skill and ability that others similarly situated ordinarily possess;

(m) failed to comply with standards of practice among physicians with the same or similar

training and experience and practicing in Catawba County or similar counties in February of 2000;

(n) failed to use best judgment and exercise reasonable care and diligence in the care and treatment of Mrs. Armstrong and Emily Armstrong;

(o) failed to exercise reasonable care and diligence in the application of knowledge and skill in the care and treatment of Mrs. Armstrong and Emily Armstrong

45. As a direct and proximate result of the negligence of Dr. Barnes as set forth herein and as imputed to Newton Women's Care, P.A., Emily Armstrong has suffered and will suffer for the rest of her life extreme mental and physical pain and suffering, has undergone and will undergo medical procedures and has permanent injuries and disfigurement and loss of the normal use of her body. Substantial medical and life care expenses have been incurred and will continue to be incurred as a result of these injuries. She also will suffer lost wages as a result of this negligence.

46. As a direct and proximate result of the defendants' negligence as set forth herein, William Earl and Sandra Armstrong have suffered and will continue to suffer severe emotional distress. Such

distress is the direct and foreseeable result of the defendants' negligence. As a direct and proximate result of the defendants' negligence, William Earl and Sandra Armstrong also have incurred and will continue to incur expenses for the education and medical treatment and other life care of their minor daughter, Emily Armstrong

SECOND CAUSE OF ACTION
(Negligence of Catawba Memorial Hospital, Inc., and Catawba Valley Medical Center, Inc.).

47. Plaintiffs incorporate paragraphs 1 through 46 of this Complaint as if fully set out herein.

48. Catawba Memorial Hospital, Inc., and through it Catawba Valley Medical Center, Inc., was negligent in that its nurses, employees, agents or servants:

(a) failed to recognize and react to a non-reassuring fetal monitor tracing;
(b) failed to adequately and appropriately assess and treat Mrs. Armstrong and Emily Armstrong;
(c) failed to provide appropriately trained and oriented personnel to care for a high risk patient and her fetus in the labor and delivery areas;

(d) failed to provide adequate intrauterine resuscitative measures;

(e) failed to provide a safe environment for a high-risk patient;

(f) failed to use Pitocin appropriately;

(g) failed to initiate the chain of command in an appropriate manner;

(h) failed to monitor a physician, with prior disciplinary history, in an appropriate manner as to ensure the safety of both Mrs. Armstrong and Emily Armstrong;

(I) failed to notify and assemble appropriate personnel and equipment for a depressed neonate;

(j) failed to provide a safe and adequate environment for the birth and resuscitation of a high risk neonate;

(k) failed to provide appropriate resuscitation for Emily Armstrong;

(l) failed to possess the degree of professional learning, skill and ability that others similarly situated ordinarily possess;

(m) failed to comply with standards of practice among nurses with the same or similar training and experience and practicing in Catawba County or similar counties in February of 2000;

(n) failed to use best judgment and exercise reasonable care and diligence in the care and

treatment of Mrs. Armstrong and Emily Armstrong;

(o) failed to exercise reasonable care and diligence in the application of knowledge and skill in the care and treatment of Mrs. Armstrong and Emily Armstrong

49. As a direct and proximate result of the negligence of Catawba Memorial Hospital, Inc., and through it Catawba Valley Medical Center, Inc., as described herein, Emily Armstrong suffered and will suffer for the rest of her life extreme mental and physical pain and suffering, has undergone and will undergo medical procedures and has permanent injuries and disfigurement and the loss of the normal use of her body. Substantial medical and life care expenses have been incurred and will continue to be incurred as a result of her injuries. She also will suffer lost wages as a result of this negligence.

50. As a direct and proximate result of the negligence of Catawba Memorial Hospital, Inc., and through it Catawba Valley Medical Center, Inc., William Earl and Sandra Armstrong have incurred and will incur medical, educational and other expenses related to the care and treatment of their daughter, Emily Armstrong As a direct and proximate result of Catawba Memorial Hospital Inc.'s negligence as set forth herein, and through it Catawba Valley Medical

Center, Inc., William Earl and Sandra Armstrong have suffered and will continue to suffer severe emotional distress. Their distress was a direct and foreseeable result of the defendants' negligence.

THIRD CAUSE OF ACTION
(Negligent Oversight and Retention of Dr. Barnes by Catawba Memorial Hospital, Inc., and Catawba Valley Medical Center, Inc.).

51. Plaintiffs incorporate paragraphs 1 through 50 of this Complaint as if fully set out herein.

52. Starting the fall of 1988, while he was an OB/GYN resident at Baptist Hospital in Winston-Salem, North Carolina, and continuing through his care of Mrs. Armstrong and Emily Armstrong Dr. Barnes repeatedly took prescription opiate medications while working as an obstetrician.

53. Upon information and belief, in 1994 Dr. Barnes' hospital privileges at Catawba Memorial Hospital were suspended for reasons related to his repeated drug use.

54. On August 31, 1994, the Board of Medical Examiners of the State of North Carolina ordered Dr. Barnes to surrender his license. In return, he was given a temporary, dated license, and told to continue

his involvement with the North Carolina Physicians Health Program for drug rehabilitation.

55. After losing his job with his former practice, Dr. Barnes started his own OB practice, Newton Women's Care, P.A., and applied to Catawba Memorial Hospital to have his privileges restored.

56. In hearings on whether Dr. Barnes should have his privileges at Catawba Memorial Hospital reinstated, officials, administrators and representatives from the hospital knew that Dr. Barnes had a long history of narcotic abuse and had suffered repeated relapses.

57. On February 14, 1995, the Medical Executive Committee of Catawba Memorial Hospital met and voted to recommend against reinstating Dr. Barnes' privileges.

58. Despite the recommendation of the Medical Executive Committee, Catawba Memorial Hospital, Inc., reinstated Dr. Barnes' privileges, and he continued to practice at Catawba Memorial Hospital until he voluntarily surrendered his license to practice medicine on May 13, 2000, less than three months after Emily Armstrong was born on February 25, 2000.

59. Dr. Barnes has not been licensed to practice medicine since surrendering his license on May 13, 2000.

60. A hospital, such as Catawba Memorial Hospital, offering a full range of obstetrical services, including caesarean sections, has a common law duty to its patients to exercise reasonable care to assess the competency of those medical providers performing such services and not to allow a medical provider to perform services the provider is not competent to perform. Further, a hospital such as Catawba Memorial Hospital has a common law duty to its patients to exercise reasonable care to review the competency of those medical providers it allows to perform such services.

61. Defendant Catawba Memorial Hospital, Inc., and through it Catawba Valley Medical Center, Inc., was negligent in that:

(a) It granted privileges to Defendant Barnes to perform obstetrical services, including laboring patients and performing a c-section on Mrs. Armstrong when it knew, or in the exercise of reasonable care should have known, that Defendant Barnes failed to possess or exercise that degree of learning, skill, care, knowledge, and diligence

ordinarily possessed or exercised by members of the same profession with similar training and experience;

(b) It granted privileges to Defendant Barnes to perform obstetrical services, including c-sections, at Catawba Memorial Hospital when it knew, or in the exercise of reasonable care should have known, that he failed to comply with standards of practice among physicians with the same or similar training and experience and practicing in Catawba County;

(c) It granted privileges to Defendant Barnes to perform obstetrical services, including c-sections, at Catawba Memorial Hospital when it knew, or in the exercise of reasonable care should have known, that he failed to use best judgment and exercise reasonable care and diligence in his treatment of patients at the hospital;

(d) It failed to monitor and review the performance of Defendant Barnes to determine his competency to provide obstetrical services and operative procedures;

(e) It failed to follow hospital policies;

(f) It failed adequately assess Dr. Barnes' abilities before granting him privileges;

(g) It failed to adequately provide ongoing monitoring of Dr. Barnes' drug dependence for the protection of patients;

(h) It failed to monitor and review the performance of Defendant Barnes to determine his competency to provide obstetrical services and operative procedures;

(i) In such other ways as may be developed during the course of this action.

62. As a direct and proximate result of the negligence of Catawba Memorial Hospital, Inc., and through it Catawba Valley Medical Center, Inc., as described herein, Emily Armstrong suffered and will suffer for the rest of her life extreme mental and physical pain and suffering, has undergone and will undergo medical procedures and has permanent injuries and disfigurement and the loss of the normal use of her body. Substantial medical and life care expenses have been incurred and will continue to be incurred as a result of her injuries. She also will suffer lost wages as a result of this negligence.

63. As a direct and proximate result of the negligence of Catawba Memorial Hospital, Inc., and through it Catawba Valley Medical Center, Inc., William Earl and Sandra Armstrong have incurred and will incur medical, educational and other expenses

related to the care and treatment of their daughter, Emily Armstrong As a direct and proximate result of Catawba Memorial Hospital Inc.'s negligence as set forth herein, and through it Catawba Valley Medical Center, Inc., William Earl and Sandra Armstrong have suffered and will continue to suffer severe emotional distress. Their distress was a direct and foreseeable result of the defendants' negligence.

FOURTH CAUSE OF ACTION
(Negligent Retention of Dr. Barnes by Newton Women's Care, P.A.)

64. Plaintiffs incorporate paragraphs 1 through 63 of this Complaint as if fully set out herein.

65. A medical provider, such as Newton Women's Care, P.A., offering a full range of obstetrical services, including caesarean sections, has a common law duty to its patients to exercise reasonable care to assess the competency of those medical providers performing such services and not to allow a medical provider to perform services the provider is not competent to perform. Further, a medical provider, such as Newton Women's Care, P.A., has a common law duty to its patients to exercise reasonable care to review the competency of those medical providers it allows to perform such services.

66. Defendant medical provider Newton Women's Care, P.A., was negligent in that:

(a) It allowed Defendant Barnes to perform obstetrical services, including laboring patients and performing a c-section on Mrs. Armstrong when it knew, or in the exercise of reasonable care should have known, that Defendant Barnes failed to possess or exercise that degree of learning, skill, care, knowledge, and diligence ordinarily possessed or exercised by members of the same profession with similar training and experience;

(b) It allowed Defendant Barnes to perform obstetrical services, including c-sections, when it knew, or in the exercise of reasonable care should have known, that he failed to comply with standards of practice among physicians with the same or similar training and experience and practicing in Catawba County;

(c) It allowed and/or credentialed Defendant Barnes to perform obstetrical services, including c-sections, when it knew, or in the exercise of reasonable care should have known, that he failed to use best judgment and exercise reasonable care and diligence in his treatment of patients;

(d) It failed to monitor and review the performance of Defendant Barnes to determine his competency to provide obstetrical services and operative procedures;

(e) It failed to follow hospital policies;

(f) It failed to adequately assess Dr. Barnes' competency before permitting him to practice;

(g) It failed to adequately provide ongoing monitoring of Dr. Barnes' drug dependence for the protection of patients;

(h) It failed to monitor and review the performance of Defendant Barnes to determine his competency to provide obstetrical services and operative procedures;

(i) In such other ways as may be developed during the course of this action.

67. As a direct and proximate result of the negligence of Newton Women's Care, PA., as described herein, Emily Armstrong suffered and will suffer for the rest of her life extreme mental and physical pain and suffering, has undergone and will undergo medical procedures and has permanent injuries and disfigurement and the loss of the normal use of her body. Substantial medical and life care expenses have been incurred and will continue to be incurred as a

result of her injuries. She also will suffer lost wages as a result of this negligence.

68. As a direct and proximate result of the negligence of Newton Women's Care, PA., as described herein, William Earl and Sandra Armstrong have incurred and will incur medical, educational and other expenses related to the care and treatment of their daughter, Emily Armstrong As a direct and proximate result of the hospital defendant's negligence as set forth herein, William Earl and Sandra Armstrong have suffered and will continue to suffer severe emotional distress. Their distress was a direct and foreseeable result of the defendant's negligence.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs pray:

1. That plaintiff Emily Armstrong, by and through her Guardian ad Litem, G. Bryan Collins, Jr., have and recover of the defendants, jointly and severally, compensatory damages in excess of $10,000.00.

2. That plaintiffs Mr. and Mrs. Armstrong each have and recover of the defendants, jointly and severally, compensatory damages in excess of $10,000.00.

3. That the plaintiffs be granted a trial by jury.

4. That the costs of this action be taxed to the defendants, including prejudgment interest as of the date of the filing of this Complaint.

5. For such other and further relief as the Court deems just and proper.

This the 21st day of February, 2003.

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E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - AFFIDAVIT OF WILLIAM B. BYSTRYNSKI - EXHIBIT B – ORDER APPROVING SETTLEMENT: ***E.M.A. v. James A. Barnes, Jr., M.D., et al.***, Catawba County, 03 CvS 525 (filed Nov. 14, 2006)

NORTH CAROLINA	IN THE GENERAL COURT OF JUSTICE
CATAWBA COUNTY	SUPERIOR COURT DIVISION 03 CvS 525

EMILY M. ARMSTRONG, By and Through Her Guardian ad Litem, STEPHANIE GIBBS, and SANDRA ARMSTRONG and WILLIAM EARL ARMSTRONG,

Plaintiffs,

v.

JAMES A. BARNES, JR., M.D.; NEWTON WOMEN'S CARE, P.A.; CATAWBA MEMORIAL HOSPITAL, INC., and CATAWBA VALLEY MEDICAL CENTER, INC.,

Defendants.

ORDER APPROVING SETTLEMENT

THIS CAUSE came on for hearing before the undersigned Superior Court Judge. The parties having appeared, the Court finds as follows:

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - AFFIDAVIT OF WILLIAM B. BYSTRYNSKI - EXHIBIT B – ORDER APPROVING SETTLEMENT: ***E.M.A. v. James A. Barnes, Jr., M.D., et al.***, Catawba County, 03 CvS 525 (filed Nov. 14, 2006)

This is a proceeding instituted by Emily M. Armstrong, a minor, by and through her Guardian ad Litem, Stephanie Gibbs, Sandra Armstrong and William Earl Armstrong against defendants James A. Barnes, M.D.; Newton Women's Care, PA.; Catawba Memorial Hospital, Inc. and Catawba Valley Medical Center, Inc., seeking to recover for injuries allegedly sustained on or about February 25, 2000, as a result of the alleged negligence of the defendants.

In this lawsuit, the plaintiffs allege that as a result of the defendants' negligence, plaintiff Emily M. Armstrong suffered severe and permanent injuries and that both parents, William Earl Armstrong and Sandra Armstrong, have incurred liability for past, present and future medical and life care expenses for treatment of Emily M. Armstrong's injuries and a claim has been made for Sandra Armstrong's severe emotional distress. The defendants deny that they were negligent in any way and deny that their care caused injury to the plaintiffs.

The minor plaintiff, Emily M. Armstrong, by and through her Guardian ad Litem, Stephanie Gibbs and adult plaintiffs Sandra Armstrong and William Earl Armstrong, have now entered into settlement with defendants James A. Barnes, M.D., Newton Women's Care, P.A., Catawba Memorial Hospital, Inc. and

Catawba Valley Medical Center, Inc., pursuant to which the minor plaintiff, Emily M. Armstrong, by and through her Guardian ad Litem, Stephanie Gibbs, and adult plaintiffs Sandra Armstrong and William Earl Armstrong, have agreed to waive and relinquish all past, present and future claims against defendants James A. Barnes, M.D., Newton Women's Care, P.A., Catawba Memorial Hospital, Inc. and Catawba Valley Medical Center, Inc., and their agents, servants, employees, officials, insurers, reinsurers, successors, assigns, and legal counsel in consideration of the payment of the sums set out in the Settlement Schedule of this Order.

The Court having reviewed the materials submitted in support of the settlement, and being aware of the complex nature of the case, the facts of the case and the extensive work performed both before and after suit was filed, and the Court having read the affidavits concerning the desires of the minor's Guardian ad Litem, Stephanie Gibbs and the minor's parents, Sandra Armstrong and William Earl Armstrong, and having determined they are satisfied with the proposed compromise and settlement and desire the same be approved:

The Court finds that said settlement with defendants James A. Barnes, M.D., Newton Women's

Care, P.A., Catawba Memorial Hospital, Inc. and Catawba Valley Medical Center, Inc., is fair and just, is in the best interest of the minor plaintiff, Emily M. Armstrong and is in all respects reasonable and proper, and it should be and is in all respects ratified, affirmed and approved by this Court.

The Court finds that it is appropriate for the Settlement Schedule describing said settlement to be filed under seal in this matter in order to preserve the confidentiality agreement entered into by the parties regarding the proposed settlement.

The Court likewise finds that said settlement is fair in all respects as to adult plaintiffs Sandra Armstrong and William Earl Armstrong. The Court finds that all claims of adult plaintiffs Sandra Armstrong and William Earl Armstrong against the defendants James A. Barnes, M.D., Newton Women's Care, P.A., Catawba Memorial Hospital, Inc. and Catawba Valley Medical Center, Inc., including, but not limited to, claims for severe emotional distress and mental anguish and liability for past, present and future medical and life care expenses, have also been resolved by the settlement with defendants James A. Barnes, M.D., Newton Women's Care, P.A., Catawba Memorial Hospital, Inc. and Catawba Valley Medical Center, Inc.

It further appears to the Court that Emily M. Armstrong suffered severe and debilitating injuries, and that the sums set out in the Settlement Schedule are fair and just compensation for her injuries.

It further appears to the Court that adult plaintiffs Sandra Armstrong and William Earl Armstrong, parents of the minor plaintiff Emily M. Armstrong have asserted claims for medical and life care expenses of their minor child, Emily M. Armstrong loss of services as a result of the injuries to Emily M. Armstrong and that Sandra Armstrong has a claim for severe emotional distress, and that the sums set out in the Settlement Schedule are fair and just compensation to them.

It further appears to the Court that the law firm of Kirby & Holt, L.L.P., has rendered good and valuable legal services for and on behalf of the plaintiffs herein, and therefore, is entitled and should receive the sum set out in the Settlement Schedule for said services.

It further appears to the Court that the law firm of Sigmon, Clark, Mackie, Hutton, Hanvey & Ferrell, P.A., has rendered good and valuable legal services for and on behalf of the plaintiffs herein, and therefore, is entitled and should receive the sum set out in the Settlement Schedule for said services.

It further appears to the Court that the law firm of Kirby & Holt, L.L.P., has incurred expenses in the prosecution of this action and is entitled to receive the sum set out in the Settlement Schedule as reimbursement for said expenses.

It further appears to the Court that the law firm of Sigmon, Clark, Mackie, Hutton, Hanvey & Ferrell, P.A., has incurred expenses in the prosecution of this action and is entitled to receive the sum set out in the Settlement Schedule as reimbursement for said expenses.

It further appears to the Court that the Division of Medical Assistance in North Carolina has asserted a lien against the proceeds of this recovery, and that the amount of that lien needs to be determined in light of the U.S. Supreme Court decision in Alabama v. Ahlborn [sic]. As a result, it appears to the Court that the maximum potential lien amount, as set out in the Settlement Schedule and as provided in N.C. Gen. Stat. § 108A-57, should be paid into the Catawba County Clerk of Court's office, to be deposited in an interest bearing account, until such time as a final ruling is made to determine the amount of the lien owed to the Division of Medical Assistance.

It further appears to the Court that Stephanie Gibbs has provided good and valuable services to the minor plaintiff, Emily M. Armstrong, as guardian ad litem.

It appears to the Court that upon entry of this Order, the cash portions of the settlement proceeds set out in the Settlement Schedule will be deposited in the trust account of Kirby & Holt, L.L.P., in accordance with this settlement; to be disbursed in accordance with the terms of this Order.

THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED AS FOLLOWS:

(1) The above-described settlement of all claims of the minor plaintiff Emily M. Armstrong against defendants James A. Barnes, M.D., Newton Women's Care, P.A., Catawba Memorial Hospital, Inc. and Catawba Valley Medical Center, Inc., is in the best interest of Emily M. Armstrong, and this Court does hereby in all respects ratify, affirm and approve such settlement.

(2) The above-described settlement of the adult plaintiffs, Sandra Armstrong and William Earl Armstrong, is in all respects fair, just and reasonable.

(3) Stephanie Gibbs, the Guardian ad Litem for the minor plaintiff Emily M. Armstrong, is hereby authorized and directed to duly execute a Settlement Agreement and Release regarding the defendants James A. Barnes, M.D., Newton Women's Care, P.A., Catawba Memorial Hospital, Inc. and Catawba Valley Medical Center, Inc., as agreed to by the parties.

(4) Adult plaintiffs Sandra Armstrong and William Earl Armstrong are hereby authorized and directed to execute a Settlement Agreements and Releases agreed to by the parties.

(5) The Special Needs Trust, a copy of which is attached hereto, is in the best interest of Emily M. Armstrong and this Court hereby establishes and approves The Emily M. Armstrong Irrevocable Special Needs Trust and authorizes said trust to receive certain periodic payments, as set out in the Settlement Agreement and Release of All Claims and as hereby ordered to be paid, such sums to be held for the use and benefit of Emily M. Armstrong.

(6) Kirby & Holt, L.L.P., is authorized and directed to pay from its trust account to The Emily M. Armstrong Irrevocable Special Needs Trust the cash sum set out in the Settlement Schedule, said sum to be held for the use and benefit of Emily M. Armstrong

(7) Kirby & Holt, L.L.P., is authorized and directed to pay from its trust account to Sandra Armstrong and William Earl Armstrong the sum set out in the Settlement Schedule by reason of claims for emotional distress, medical and life care expenses of Emily M. Armstrong and loss of services.

(8) Kirby & Holt, L.L.P., is authorized and directed to pay from its trust account to the law firm of Kirby & Holt, L.L.P., the sum set out in the Settlement Schedule for all attorney's fees payable to this firm by reason of the legal services provided herein.

(9) Kirby & Holt, L.L.P., is authorized and directed to pay from its trust account to the law firm of Sigmon, Clark, Mackie, Hutton, Hanvey & Ferrell, P.A., the sum set out in the Settlement Schedule for all attorney's fees payable to this firm by reason of the legal services provided herein.

(10) Kirby & Holt, L.L.P., is authorized and directed to pay from its trust account to the law firm of Kirby & Holt, L.L.P., the sum set out in the Settlement Schedule as reimbursement for expenses incurred in this case.

(11) Kirby & Holt, L.L.P., is authorized and directed to pay from its trust account to the law firm of Simon, Clark, Mackie, Hutton, Hanvey & Ferrell, PA., the sum set out in the Settlement Schedule as reimbursement for expenses incurred in this case.

(12) Kirby & Holt, L.L.P., is authorized and directed to pay from its trust account to Stephanie Gibbs, the sum set out in the Settlement Schedule for good and valuable services performed as Guardian ad Litem for the minor plaintiff, Emily M. Armstrong

(13) Defendants James A. Barnes, M.D. and Newton Women's Care, P.A., and their insurer, are authorized and directed to pay into the Catawba County Clerk of Court's office the sum set out in the Settlement Schedule as the maximum potential amount of the Medicaid lien, as provided by N.C. Gen. Stat. § 108A-57, to be held in an interest-bearing account until such time as the actual amount of the lien owed by Emily M. Armstrong to the North Carolina Division of Medical Assistance is conclusively judicially determined. **[IN HAND WRITING: These funds can only be ordered to pay the lien or distributed to the Emily M. Armstrong Irrevocable Special Needs Trust. TSK]**

(14) Stephanie Gibbs, in her capacity as Guardian ad Litem for Emily M. Armstrong is authorized and directed to file a Notice of Voluntary Dismissal With Prejudice as to the defendants James A. Barnes, M.D., Newton Women's Care, P.A., Catawba Memorial Hospital, Inc. and Catawba Valley Medical Center, Inc. as soon as defendants' payments herein are cleared funds in the trust account of Kirby & Holt, LLP and all of the defendants' obligations under this Order and the Settlement Agreement are completed.

(15) Adult plaintiffs Sandra Armstrong and William Earl Armstrong are authorized and directed to file a Notice of Voluntary Dismissal With Prejudice as to the defendants James A. Barnes, M.D., Newton Women's Care, P.A., Catawba Memorial Hospital, Inc. and Catawba Valley Medical Center, Inc., as soon as defendants' payments herein are cleared funds in the trust account of Kirby & Holt, LLP and all of the defendants' obligations under this Order and the Settlement Agreement are completed.

(16) Plaintiffs and defendants shall bear their own costs.

(17) The Settlement Schedule to this Order shall be filed under seal. Any request to open this document should be addressed to a Resident Superior Court

Judge of Catawba County and said request shall not be considered unless and until notice and an opportunity to respond is given to the parties herein.

IT IS SO ORDERED.

This the 14th day of November, 2006.

/s/ Timothy S. Kincaid
The Honorable Timothy S. Kincaid
Senior Resident
Superior Court Judge

CONSENTED TO BY:
KIRBY & HOLT, L.L.P.
/s/ C. Mark Holt
C. Mark Holt
Attorney for Plaintiffs
P.O. Box 31665
Raleigh, North Carolina 27622-1665

/s/ Stephanie Gibbs
Stephanie Gibbs in her capacity
as Guardian ad Litem for Emily M. Armstrong

/s/ Sandra Armstrong
Sandra Armstrong
Individually, and as parent and natural guardian of Emily M. Armstrong

/s/ William Earl Armstrong
William Earl Armstrong
Individually, and as parent and natural guardian of Emily M. Armstrong

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - AFFIDAVIT OF WILLIAM B. BYSTRYNSKI - EXHIBIT C – Affidavit of Cynthia L. Wilhelm, Ph.D. (dated Mar. 20, 2007)

AFFIDAVIT OF CYNTHIA L. WILHELM, Ph.D

Cynthia L. Wilhelm, first being duly sworn, deposes and says:

1) My name is Cynthia L. Wilhelm I am an Associate Professor, Emeritus, of Rehabilitation, Division of Rehabilitation Psychology and Counseling, Department of Allied Health Sciences, School of Medicine, at the University of North Carolina at Chapel Hill.

2) For the past 23 years I have also worked as a private consultant and life care planner.

3) I am a Diplomats of the American Board of Professional Disability Consultants.

4) I spent 19 years as an Associate Professor of Rehabilitation, at the school of Medicine, University of North Carolina at Chapel Hill.

5) I hold a Ph.D from Indiana State University in Counseling Psychology, Vocational and Educational Evaluation, along with an M.S. from Indiana State in Clinical Psychology.

6) I completed a Postdoctoral Fellowship in Clinical Child/Adult Psychology/Rehabilitation

at the University of North Carolina at Chapel Hill.

7) I have been consulted by hundreds of patients and families involving the future medical needs of injured persons, and have extensive experience in the medical needs of children who suffer from cerebral palsy.

8) Attached to this affidavit is a true and accurate copy of my CV. [omitted in printing]

9) As part of the work I do, I develop life care plans for patients in conjunction with their physicians, to determine what medical needs and services they are likely to require over their lifetime.

10) I was retained as an expert by plaintiffs' counsel in the case of Emily M. Armstrong, By and Through Her Guardian ad Litem Stephanie Gibbs *et al.* v James A. Barnes, Jr., M.D. *et al.* I was asked to evaluate Emily Armstrong's injuries, and, in conjunction with her physicians, determine her expected medical needs, and the present-day cost of meeting those needs.

11) In determining those needs, I looked at the medical and therapy evaluations that she will

need, the equipment, transportation and attendant care she requires, the medication and supplies she needs, along with renovations to her home to adapt it to her wheelchair and disabilities. I did not estimate the cost of the many potential complications and surgeries Emily is likely to need during her lifetime.

12) A true and accurate copy of my report is attached.

13) Based on my training and experience in life care planning, I am of the opinion that Emily Armstrong will need the therapies, equipment, medications, evaluations and architectural renovations outlined in my Life Care Plan.

Further, affiant sayeth not.

This the 20th day of March, 2007.

/s/ Cynthia L. Wilhelm
Cynthia L. Wilhelm

[Jurat omitted in printing]

[Curriculum Vita of Wilhelm omitted in printing]

PRELIMINARY RECOMMENDATIONS SECTION OF LIFE CARE PLAN FOR Emily Armstrong

1) **Medical Evaluations**: Emily Armstrong will need to be followed annually for evaluations. These evaluations will include pediatrician, pulmonologist, orthopedist, gastroenterologist (surgeon), neuroophthalmologist, ENT, specialized dentist, physical therapist, occupational therapist and speech therapist. Laboratory tests and x-rays will also be required.

2) **Therapy Evaluations**: Emily Armstrong will require ongoing therapies to aid in her development and prevent future medical complications. These therapies include physical therapy, occupational therapy, and speech therapy. Rehabilitation psychology/educational consultant and case manager will be required.

3) **Equipment**: Emily Armstrong will require various types of equipment to aid in her development, therapeutic treatment, and personal care. Items are listed in Cost Analysis Section.

4) **Transportation**:. Due to Emily Armstrong's disability she requires an adapted van for transportation needs.

5) **Home/Facility Care**: Emily Armstrong is totally dependent upon others for her care and this is a permanent condition. She will require 24-hour attendant care throughout her entire life expectancy.

6) **Medications and Supplies**: Emily Armstrong presently is on the following medications: Lamictal, Zanaflex, Robinul, Zonegran, Antibiotics (Augmentin, etc.), Klonopin, Prevacid Solution, Benadry1, Zyrtec, MiraLax, Benefiber, and Glycerine Suppositories. She does require supplies for her care including: feeding supplies, diapers, gloves, etc. Costs have been listed in the Cost Analysis Section for drugs and supplies.

7) **Potential Complications/Surgeries**: Emily Armstrong has the potential for various medical complications/surgeries, i.e., respiratory, contratures, gastroenterology, neuroophthalmology and nutritional complications/ surgeries may be required.

8) **Architectural Renovations**: The Armstrong's house will require extensive architectural

changes due to Emily's disability and additionally Emily will require renovation of her own home when she reaches adulthood. A local builder will estimate the costs.

9) **Vocational Loss**: Emily Armstrong is permanently disabled and is totally dependent. Her disability makes placement in the competitive labor market impossible. Total loss of earning capacity is expected.

10) **Additional Costs**:

- Past medical costs have not been included in this report.
- Future in-home productions costs have not been included in this report.
- Past and future vocational losses for the Armstrong family due to Emily Armstrong's medical treatment have not been included in this report.
- Cost of past attendant care services provided by Emily Armstrong's family have not been included in this report.

- Past costs for home adaptation for Emily Armstrong due to her disability have not been included in this report.

PRELIMINARY COST ANALYSIS SECTION OF LIFE CARE PLAN FOR EMILY ARMSTRONG
Projected

[Page number omitted in printing]

Evaluations	Age	Frequency	Cost
Pediatrician	Age 7 Years - Life Expectancy	10-15 X Years	$930.00-1,395.00/Year
Lab Tests:	Ages 7 Years -Life Expectancy		
CBC		10 X Year	$510.00/Year
Anticonvulsant Medication Levels		1-2 X Year	Not Estimated
Liver Function Test		1 X Year	Not Estimated
*Neurologist	Ages 7 Years-Life Expectancy	Not Estimated	Not Estimated
*Gastroenterologist/ Surgeon	Ages 7 Years-Life Expectancy	1 X Year	Approximately $85.00/Year
*Pulmonologist	Ages 7 Years-Life Expectancy	4-6 X Year	$492.00-738.00/Year
**Pulmonary Function Tests/Additional Outpatient Tests	Ages 7 Years-Life Expectancy	4-6 X Year	Approximately $884.00-1,572.00/Year
*Orthopaedist	Ages 7-10 Years	1 X Year	$126.00/Year
	Ages 11-18 Years	1 X Year	$126.00/Year
X-Rays	Ages 7-18 Years	prn	Not Estimated
*Neuro-ophthalmologist	Ages 7 Years-Life Expectancy	1 X Year	$123.00/Year
*ENT	Ages 7 Years-Life Expectancy	prn	Not Estimated
Internist or Physiatrist	Ages 19 Years - Life Expectancy	2-4 X Year	$246.00-490.00/Year
Physical Therapy Evaluation	Ages 7 Years - Life Expectancy	1 X Year	$176.00-264.00/Year
Occupational Therapy Evaluation	Ages 7 Years - Life Expectancy	1 X Year	$180.00-260.00/Year
*Nutritionist	Ages 7 Years - Life Expectancy	3 X Year	Approximately $450.00/Year
Case Manager	Ages 7 Years - Life Expectancy	3.5 Hours/ Month	$2,321.04-3,792.00/Year
Dental Evaluation	Ages 7 Years - Life Expectancy	1-2 X Year	$232.00/Year

*Costs are approximations - awaiting feedback from specialist.
**Pulmonary function, CO_2, capnograph and pulse oximetry.

Projected Therapeutic Modalities

Modality	Age	Frequency	Cost
Physical Therapy	Ages 7 Years - Life Expectancy	1 X Week	$4,997.00-6,000.00/ Year
Occupational Therapy	Ages 7 Years - Life Expectancy	1 X Week	$4,997.00-6,000.00/ Year

Projected Equipment Needs

Equipment	Age	Frequency	Cost
Hospital Bed with Mattress	Ages 8 Years - Life Expectancy	Replace Every 10 Years	$3,500-4,800/ Each
Maintenance	Ages 8 Years - Life Expectancy	Yearly	$100.00/Year
Zippie Tilt-in-Space Wheelchair with Specialized Seating and Accessories	Ages 7-12 Years	Replace 1 X Every 3 Years	$8,066.68/Each
	Ages 13 Years - Life Expectancy	Replace 1 Every 5 Years	$8,066.68/Each
Maintenance	Ages 8 Years - Life Expectancy	Yearly	Not Estimated
Wheelchair Carry Pocket	Ages 7 Years - Life Expectancy	Replace Every 2-3 Years	$30.00-40.00/Each
Pulse Oximeter	Ages 7 Years - Life Expectancy	Replace Every 5 Years	$675.00-1,250.00/Each
Supine Stander with Tray (Rifton)	Ages 10 Years - Life Expectancy	Replace Every 10 Years	$2,011.25/Each
Portable Ramp(s)	Ages 7 Years - Life Expectancy	Replace Every 20 Years	$395.00/Each
Therapeutic Mat	Age 7 Years	1 X Only	$600.00-900.00/Each
	Ages 17 & 27 Years	At Specified Ages	$900.00-1,200.00/Each
*Orthotics: AFO (DAFO)	Ages 7 Years - Life Expectancy	Replace Every 1 X Year	Approximately $1,100.00/Each

Kangaroo Feeding Pump	Ages 7 Years - Life Expectancy	Replace Every 5-7 Years	$582.00-1,474.00/Each
Nebulizer	Ages 7 Years - Life Expectancy	1 X Every 5 Years	$150.00/Each
Portable Suction Machine	Ages 7 Years - Life Expectancy	1 X Every 5 Years	$339.94-632.00/Each
Permanent Suction Machine	Ages 7 Years - Life Expectancy	1 X Every 5 Years	Approximately $1,054.00/Each
O2 Concentrator	Ages 7 Years - Life Expectancy	Replace Every 5 Years	$1,218.00-2,490.00/Each
Portable Gaseous Oxygen System	Ages 7 Years - Life Expectancy	Replace Every 5 Years	$1,668.00/Each
PT Vest	Ages 7 Years - Life Expectancy	Replace Every 5-10 Years	$16,425.00/Each
Permanent Suction Machine	Ages 7 Years - Life Expectancy	1 X Every 5 Years	Approximately $1,054.00/Each

***Dependent upon physical therapy and occupational therapy evaluations.**

Transportation

Transportatin	Age	Frequency	Cost
*Van with Adaptive Equipment	Ages 7 Years - Life Expectancy	Replace Every 5 Years	Approximately $42,043.00-54,000.00/Each
Maintenance (Labor Only - Does Not Include Parts)	Ages 8 Years - Life Expectancy	2 X Year	$400.00-600.00/Year

***Costs obtained from Ilderton, High Point, NC. Trade in value will be estimated by economist.**

Skilled Home Care

Care	Age	Frequency	Cost
Attendant Care: LPN/RN	Ages 7 Years - Life Expectancy	24 Hours/ Day X 7 Days/Week (Based on $36.44-45.00/ Hour)	$319,214.40-394,200.00/Year

Medication/Supply Needs
Routine Pharmaceuticals and Supplies

Medication/Supply	Age	Frequency	Cost
Lamictal	Ages 7 Years-Life Expectancy	100 mg b.i.d.	$2,749.56/Year
Zanaflex	Ages 7 Years-Life Expectancy	1 mg b.i.d.	$935.92/Year
Robinul	Ages 7 Years-Life Expectancy	1.5 mg (2 tablets q.d.)	$2,094.84/Year
Zonegran	Ages 7 Years-Life Expectancy	100 mg t.i.d.	$2,419.56/Year
Zyrtec	Ages 7 Years-Life Expectancy	5 ml q.d.	$827.52/Year
Klonopin	Ages 7 Years-Life Expectancy	1 mg b.i.d.	$971.28/Year
Benadryl	Ages 7 Years-Life Expectancy	prn	Not Estimated
Prevacid Solution	Ages 7 Years-Life Expectancy	15 mg q.d.	$1,631.52/Year
Antibiotics (Augmentin; etc.)	Ages 7 Years-Life Expectancy	3-6 X Year	$313.00-826.00/ Year
Miralax	Ages 7 Years-Life Expectancy	1 tsp. q.d.	$250.14-500.28/Year
Benefiber	Ages 7 Years-Life Expectancy	1 tsp. b.i.d.	$203.88/Year
Glycerinc Suppository	Ages 7 Years-Life Expectancy	prn	$17.12-228.00/Year
Diapers	Ages 7 Years-Life Expectancy	288/Month	$3,088.80/Year
Sterile Cotton Tip Applicator	Ages 7 Years-Life Expectancy	100/Month	$72.00/Year
30 cc Syringe without Needle	Ages 7 Years-Life Expectancy	5/Month	$64.80/Year
10 cc Syringe without Needle	Ages 7 Years-Life Expectancy	10/Month	$37.20/Year
Enteral Feeding Supply Kit	Ages 7 Years-Life Expectancy	30/Month	$3,967.20/Year
Canister for Suction Pump (Disposable)	Ages 7 Years-Life Expectancy	1/Month	$98.40/Year
Tracheal Suction Catheter	Ages 7 Years-Life Expectancy	50/Month	$1,260.00/Year
Low Profile Gastrostomy Kit	Ages 7 Years-Life Expectancy	1/Month	$1,577.28/Year
Tubing for Suction Pump	Ages 7 Years-Life Expectancy	2/Month	$74.16/Year

Non-Sterile Gloves	Ages 7 Years-Life Expectancy	2 Boxes/ Month	$262.08/Year
Sterile Gloves	Ages 7 Years-Life Expectancy	9/Month	$91.80/Year
PediaSure with Fiber	Ages 7 Years-Life Expectancy	Daily	$1,450.08/Year
Resource Benefiber	Ages 7 Years-Life Expectancy	Daily	$184.92/Year
Needle Only (Sterile)	Ages 7 Years-Life Expectancy	17/Month	$28.56/Year
Huber Needle	Ages 7 Years-Life Expectancy	2/Month	$120.00/Year
Sterile Saline (3 cc Vial)	Ages 7 Years-Life Expectancy	50/Month	$192.00/Year
Sterile Water	Ages 7 Years-Life Expectancy	Daily	$2,298.24/Year
G-tube Supplies	Ages 7 Years-Life Expectancy	Daily	Approximately $1,000.00-1,500.00/Year
Additional Supplies	Ages 7 Years-Life Expectancy	Daily	Not Estimated

Potential Complications/Surgeries

Complications/ Surgeries	Age	Frequency	Cost
Orthopaedic Problems/Surgery (Contractures)	Ages 7 Years-Life Expectancy	Not Estimated	Not Estimated
Gastroenterological Complications (Fundoplication Revision/Redo)	Ages 7 Years-Life Expectancy	Not Estimated	Not Estimated
Pulmonary/ Respiratory Disorders	Ages 7 Years-Life Expectancy	Not Estimated	Not Estimated
Neurological Complications	Ages 7 Years-Life Expectancy	Not Estimated	Not Estimated
Hospitalization for Complications/ Additional Medical Tests	Ages 7 Years-Life Expectancy	Not Estimated	Not Estimated

Architectural Renovations

For a severely disabled child to be cared for in the home, it is essential to consider all of the renovations necessary to provide a safe, accessible, barrier-free environment. Accessibility for a home environment for a person with a severe disability would require architectural design or redesign of:

1. Ramping
2. Floor covering
3. Hallways
4. Doorways
5. Window changes
6. Bathroom (additional accessible bathroom for Emily Armstrong)
7. Therapy/equipment storage
8. Outside accessibility for yard
9. Additional space for wheelchair (inside/outside home)
10. Attached garage

(List not inclusive.)

Architectural Renovations

Renovations	Age	Frequency	Cost
Present Living Situation	Age 7 Years	1 X Only	$36,953.00-60,596.00
Future Home for Emily Armstrong	Age 19 Years	1 X Only	$36,953.00-60,596.00

National statistics estimate costs for renovations for a, barrier-free environment range from $36,953.00 to $60,596.00. Specific costs will depend on the level of renovations necessary in the home selected. Average costs range $48,749.00 (Blackweil, TL., Weed, R.O., & Powers, A.S., 1994). Does not include home generator.

Past architectural renovation costs for Emily Armstrong have not been included.

Vocational Loss

Vocationally, pre-accident, Emily Armstrong's choice of careers was open. This projection is based on parents' educational and vocational history, which are the best predictors due to age at onset of disability. Post-injury, Emily has the need for continuous care services throughout her life expectancy. Emily is functioning at too low a level to be considered for

placement in the labor market thus eliminating any placement in the competitive labor market. More likely than not, pre-disability, Emily would have minimally finished high school and likely two years of college given her family's education and employment history. Total compensation for loss of earning will be required.

Vocational Handicaps: Restrictions, limitations, and/or deficits are consistent with cerebral palsy that include motoric, cognitive, and speech deficits. These handicaps result in the requirement for care services throughout life expectancy.

Impact on Placement - Severe: Emily Armstrong's severe vocational handicaps and motoric, cognitive, and speech deficits make placement in the competitive labor market impossible.

Vocational Development Option - Pre-onset: It is anticipated that Emily Armstrong would have been employed directly after high school or two-year associate degree.

Vocational Development Option - Post-onset: Total loss of earning capacity is expected and will be estimated by the economist.

Additional Costs

- Past medical costs have not been included in this report.
- Future in-home productions costs have not been included in this report.
- Past and future vocational losses for the Emily Armstrong's family due to Emily Armstrong's medical treatment have not been included in this report.
- Cost of past attendant care services provided by Emily Armstrong's family have not been included in this report
- Past costs for home adaptation for Emily Armstrong due to her disability have not been included in this report.

/s/ Cynthia L. Wilhelm/ jr. — September 14, 2006
Cynthia L. Wilhelm, Ph.D. — Date

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - AFFIDAVIT OF WILLIAM B. BYSTRYNSKI - EXHIBIT D – Affidavit of J. Finley Lee, Ph.D.(dated Mar. 20, 2007)

AFFIDAVIT OF J. FINLEY LEE, Ph.D

J. Finley Lee, first being duly sworn, deposes and says:

1) My name is J. Finley Lee. I am the Julian Price Professor of Business Administration, Emeritus, of the University of North Carolina at Chapel Hill.

2) For 22 years I was a Professor of Business Administration at the University of North Carolina at Chapel Hill, and during a portion of that time I was the director of the MBA program at the University.

3) I hold a Ph.D from the University of Pennsylvania in the field of Applied Economics and Business Administration.

4) I have done private economic consulting for the Internal Revenue Service, The U.S. Department of Commerce, the American Insurance Association, the North Carolina General Assembly, the Department of Education, and the Office of the Attorney General, among many other clients.

5) I have been a member of the board of directors for several banks, investment groups and insurance companies.

6) I have been consulted by hundreds of clients and their attorneys regarding the present value of future medical needs for injured persons, and I have extensive experience in calculating the present value of future medical needs of children who suffer from cerebral palsy.

7) Attached to this affidavit is a true and accurate copy of my resume. [omitted in printing]

8) As part of the work I do, I develop economic appraisals of the present value of the economic loss of persons who are injured.

9) I was retained as an expert by plaintiff's counsel in the case of Emily M. Armstrong, By and Through Her Guardian ad Litem Stephanie Gibbs *et al.* v. James A. Barnes, Jr., M.D. *et al.* In that case I was asked by lawyers for Emily Armstrong to use the life care plan developed by Cynthia L. Wilhelm and determine the present value of the costs of products and services needed by Emily Armstrong over her lifetime as a result of her injuries. That evaluation is reflected in Table B of the attached report.

10) In addition, I was asked to determine the present value of the economic loss of Emily Armstrong, and those estimates are reflected in Tables A-1 and A2 of the attached report. Table A-1 reflects income if Emily Armstrong had a high school education, and Table A-2 reflects the economic loss of Emily Armstrong attended college.

11) A true and accurate copy of my report is attached.

12) Based on my training and experience in economics and based on the estimates supplied by Cynthia Wilhelm, I am of the opinion that the present value of the goods and services required by Emily Armstrong during her projected lifetime is $41,099,962.

Further, affiant sayeth not.

This the 20th day of March, 2007.

/s/ J. Finley Lee
J. Finley Lee

[Jurat omitted in printing]

[Resume of Lee omitted in printing]

PRELIMINARY

ECONOMIC APPRAISAL

PRESENT VALUE OF THE ECONOMIC LOSS OF

Emily Armstrong

Prepared by:

J. Finley Lee

September 20, 2006

PRELIMINARY

AGGREGATE TABLE A-1

PRESENT VALUE OF THE ECONOMIC LOSS OF

Emily Armstrong

TOTAL ECONOMIC LOSS (INCOME)

FOR REASON OF PERMANENT AND TOTAL DISABILITY

= $850,941 to age 65

ASSUMPTIONS

A. Employment from age 18 to age 65
B. Income, salary, or wage capacity* = $8.50 per hour (High School, Entry Level)
C. Future income adjusted and present value at net discount rate = (.77%)
D. Discounted for mortality
E. Discounted for morbidity
F. Discounted for early retirement
G. Discounted for income taxes
H. Discounted for unemployment

* Plus fringe benefits at 12.5 percent of gross wage.

ATTACHMENT

TO PRELIMINARY AGGREGATE TABLE B

SPECIFICATIONS

OF THE COSTS OF PRODUCTS AND SERVICES

For Emily Armstrong

Products and Services	Present Values
Projected Evaluations:	$ 862,157
Projected Therapeutic Modalities:	1,150,569
Projected Equipment Needs:	282,003
Transportation:	304,636
Skilled Home Care:	37,320,733
Medication/Supply Needs:	1,092,760
Architectural Renovations:	87,104
TOTAL:	$41,099,962

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - AFFIDAVIT OF WILLIAM B. BYSTRYNSKI - EXHIBIT E – Affidavit of Sandra Armstrong: *State v. E.M.A., et al.*, Catawba County, 07 CvS 3413 (filed Jan. 12, 2009)

NORTH CAROLINA	IN THE GENERAL COURT OF JUSTICE
CATAWBA COUNTY	SUPERIOR COURT DIVISION 07 CvS 3414

THE STATE OF NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE,

PLAINTIFF,

v.

AFFIDAVIT OF SANDRA ARMSTRONG

EMILY ARMSTRONG, by and through her guardian ad litem, STEPHANIE GIBBS, SANDRA ARMSTRONG AND WILLIAM ARMSTRONG, Individually,

Defendants.

Sandra Armstrong, first being duly sworn, deposes and says:

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - AFFIDAVIT OF WILLIAM B BYSTRYNSKI - EXHIBIT E – Affidavit of Sandra Armstrong: *State v. E.M.A., et al.*, Catawba County, 07 CvS 3413 (filed Jan. 12, 2009)

1. I am the natural mother of Emily Armstrong, who lives with me in our family's home in Taylorsville, N.C.

2. I care for Emily on a daily basis and I am very familiar with Emily's medical conditions.

3. I was a plaintiff in the case of Emily Armstrong, by and through her guardian *ad litem*, G. Bryan Collins Jr., *et al.* v. James A. Barnes Jr., M.D., *et al.*, 03 CvS 525, filed in Catawba County Superior Court.

4. As a result of injuries she suffered at birth, Emily cannot crawl, walk, or talk. She cannot feed herself or be fed through her mouth, so she is fed through a tube in her stomach. She is legally blind and is deaf. She suffered a severe brain injury at birth which has left her mentally retarded and with severe deficits in all activities of daily living.

5. Emily has difficulty clearing and controlling her secretions because of the lack of use of muscles in her mouth and throat. Consequently, she requires frequent suctioning so that she does not gag on her own saliva.

6. Emily has a seizure disorder and requires medications to control this condition. These medications are administered through her feeding tube.

7. Emily has no control of her bowel or bladder function and requires vigilant attention to keep her clean and dry so that she does not suffer from skin breakdown and infections.

8. Emily receives between 12 and 18 hours of nursing care a day.

9. Emily Armstrong is completely dependent on others for all aspects of her care and is expected to be so for the remainder of her life.

10. These physical conditions were present on November 13, 2006, the day Emily's settlement was approved by Judge Timothy Kincaid, and remain present today. In that lawsuit, it was alleged that these physical conditions were caused by the negligence of the defendants.

Further, affiant sayeth not.

This the 8th day of January, 2009.

/s/ Sandra Armstrong
Sandra Armstrong

[Jurat and Certificate of Service omitted in printing]

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - AFFIDAVIT OF WILLIAM B. BYSTRYNSKI - EXHIBIT F – Letter to NC DHHS DMA re Mediated Settlement Conference in *E.M.A., et al. v. James A. Barnes, Jr., M.D., et al.*, Catawba County, 03 CvS 525 (dated September 13, 2006)

KIRBY&HOLT LLP
ATTORNEYS AT LAW
[Letterhead and Page numbering omitted in printing]

September 13, 2006

Ms. Beverly Tide
Field Investigator
Third Party Recovery Section
Division of Medical Assistance
North Carolina Department of
Health and Human Services
2508 Mail Service Center
Raleigh, North Carolina 27699-2508

Re: *Emily M. Armstrong., et al. v. Barnes, et al.*
No 03 CvS 525 - Catawba County
(Medicaid File No. **04-04861**)

Dear Ms. Tide:

Pursuant to Rule 4B of the Mediated Settlement Conference Rules as amended (copy enclosed), this letter is sent to carry out my responsibility to notify you, as a lienholder, that a mediation settlement conference of the above-referenced case is scheduled

for Wednesday, September 27, 2006, at 10:00 a.m. in the offices of Cranfill, Sumner & Hartzog, LLP, 225 Hillsborough Street, Raleigh, North Carolina. As requested by Rule 4B, please attend the conference or make a representative available with whom to communicate during the conference.

Also, please provide us with an updated statement concerning the current balance of your lien.

Please contact me if you have any questions or concerns about this notice and request. Thank you for your attention to this matter.

With best regards,

Sincerely,

KIRBY & HOLT, L.L.P.

/s/ C. Mark Holt
C. Mark Holt

CMH/acp
Enclosure
cc:Jeff Mackie
Dave Batten/Jaye Bingham
Dennis Bailey
Rene Ellis

NORTH CAROLINA	IN THE GENERAL COURT OF JUSTICE
CATAWBA COUNTY	SUPERIOR COURT DIVISION 03 CvS 525

EMILY M. ARMSTRONG, By and Through Her Guardian ad Litem, STEPHANIE GIBBS, and SANDRA ARMSTRONG and WILLIAM EARL ARMSTRONG,

Plaintiffs,

v.

JAMES A. BARNES, JR., M.D.; NEWTON WOMEN'S CARE, P.A.; CATAWBA MEMORIAL HOSPITAL, INC., and CATAWBA VALLEY MEDICAL CENTER, INC.,

Defendants.

NOTICE OF HEARING

PLEASE TAKE NOTICE that the plaintiffs, through counsel, will bring on for hearing their Petition for Approval of Minor's Settlement before the Court at the Catawba County Courthouse in Newton

on November 13, 2006, at 10:00 a.m. or as soon thereafter as counsel can be heard.

This the 27 day of October, 2006.

KIRBY & HOLT, L.L.P.

/s/ C. Mark Holt
C. Mark Holt
Attorney for Plaintiffs
P.O. Box 31665
Raleigh, North Carolina 27622
(919) 881-2111

SIGMON, CLARK, MACKIE, HUTTON, HANVEY & FERRELL, P.A.

/s/ Jeffrey T. Mackie
Jeffrey T. Mackie
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[Certificate of Service omitted in printing]

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - MOTION FOR SUMMARY JUDGMENT ON PLAINTIFF'S CLAIMS (filed Oct. 15, 2009)

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT
OF NORTH CAROLINA
CASE NO. 5:07-CV-37-RLV

E.M.A., a minor by and Through Her Guardian ad Litem, STEPHANIE J. GIBBS, WILLIAM EARL ARMSTRONG and SANDRA ARMSTRONG,

Plaintiffs,

v.

LANIER CANSLER, in his official capacity as secretary of the North Carolina Department of Health and Human Services,

Defendant.

MOTION FOR SUMMARY JUDGMENT ON PLAINTIFFS' CLAIMS

Fed. R. Civ. P. 56

Defendant, the Secretary of the North Carolina Department of Health and Human Services, in his official capacity, respectfully moves the Court pursuant to Rule 56, Federal Rules of Civil Procedure, for summary judgment as to the claims presented by Plaintiffs on the ground that there is no genuine issue as to any material fact and defendant is entitled to judgment as a matter of law. In support of this

motion, Defendant submits the attached Exhibit Index and Exhibit A Redacted Copy of Medical Malpractice Complaint, Catawba County Superior Court, 03 CVS 525; Exhibit B - Redacted Copy of Superior Court Order Approving Settlement, Catawba County Superior Court, 03 CVS 525; Exhibit C - N.C. Gen. Stat. § 108A-57; and Exhibit D - N.C. Gen. Stat. § 108A-59.

Respectfully submitted, this the 15th day of October, 2009.

ROY COOPER
Attorney General

/s/ Belinda A. Smith
Belinda A. Smith
Special Deputy Attorney General
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[Certificate of Service omitted in printing]

E.M.A. v. Cansler, Secretary of NC DHHS, W.D.N.C., 5:07-CV-00037 - MOTION FOR SUMMARY JUDGMENT ON PLAINTIFF'S CLAIMS (filed Oct. 15, 2009)

(Exhibits A & B printed in Pet. App. 114a-115a, 116a-117a)

(Exhibits C&D are the same as attachments A and B to Affidavit of William B. Bystrynski at J.A. 49-76 and J.A. 77-88, respectively)

PETITIONER'S BRIEF

RECORD
AND
BRIEFS

No. 12-98

Supreme Court, U.S.
FILED
NOV 9 - 2012
OFFICE OF THE CLERK

In the
Supreme Court of the United States

ALBERT A. DELIA, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

E.M.A., A MINOR, BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON, WILLIAM EARL ARMSTRONG AND SANDRA ARMSTRONG,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF FOR THE PETITIONER

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November 2012 * Counsel of Record

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QUESTION PRESENTED

The Medicaid Act requires participating states to seek reimbursement from third-party tortfeasors for health-care expenditures they made to Medicaid recipients who are tort victims. 42 U.S.C. §§ 1396a(a)(25), 1396k(a) (2006). To enforce that requirement when the recipient and a third-party resolve their tort dispute through judgment or settlement, North Carolina law provides that the State has a subrogation right to, and may assert a lien upon, the lesser of one-third of the recipient's recovery or the State's actual medical expenditures. N.C. Gen. Stat. § 108A-57 (2011).

The question presented is whether N.C. Gen. Stat. § 108A-57 is preempted by the Medicaid Act's anti-lien provision as it was construed in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), an issue on which the North Carolina Supreme Court and the United States Court of Appeals for the Fourth Circuit are in conflict.

LIST OF PARTIES TO THE PROCEEDING BELOW

Appellants listed by the court below were E.M.A., a minor, by and through her Guardian *ad Litem*, William W. Plyler, William Earl Armstrong and Sandra Armstrong. By Order filed May 18, 2012, the United States District Court of the Western District of North Carolina substituted Daniel Johnson for William W. Plyler as the Guardian *ad Litem*.

Appellee below was Lanier M. Cansler, in his official capacity as Secretary of the North Carolina Department of Health and Human Services. The current Acting Secretary of the North Carolina Department of Health and Human Services is Albert A. Delia. By Order filed May 29, 2012, the United States District Court of the Western District of North Carolina modified the caption of the case below to reflect the substitution.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit (Pet. App. 1a-70a) is reported at 674 F.3d 290. The opinion of the United States District Court for the Western District of North Carolina (Pet. App. 71a-85a) is reported at 722 F. Supp. 2d 653.

JURISDICTION

The judgment of the United States Court of Appeals for the Fourth Circuit was entered on March 22, 2012. (Pet. App. 1a-70a) On June 14, 2012, the Chief Justice extended the time within which to file a petition for writ of certiorari to and including July 20, 2012. The petition was granted on September 25, 2012. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant provisions are reprinted in an appendix to the petition. (Pet. App. 114a-123a)

STATEMENT

North Carolina participates in the jointly-funded, cooperative federal-state program established by Title XIX of the Social Security Act, which is also known as the Medicaid Act, 42 U.S.C. § 1396, *et seq.* The Medicaid Act authorizes federal funding so that the states can provide payments for medical assistance to qualifying needy individuals who are unable to afford their own medical costs. Funding is conditioned on the adoption of a State Plan that complies with specific federal requirements. 42 U.S.C. § 1396a (2006). The North Carolina Department of Health and Human Services ("DHHS") is the regulatory body charged with establishing and administering the State's Medicaid program. N.C. Gen. Stat. § 108A-54 (2011).

In North Carolina, the federal funding component specified in 42 U.S.C. § 1396b has ranged from 64% to 71% during the State's last five fiscal years. Medicaid spending accounts for over 20 percent of the average state's total budget; states devote a larger percentage of their budgets to Medicaid than to any other item. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2604, 2663 (2012) (citing Nat'l Ass'n of State Budget Officers, Fiscal Year 2010 State Expenditure Report, p. 11, Table 5 (2011)).

A. Medicaid Is the Payer of Last Resort.

Participation in the Medicaid program is optional, but once a state chooses to participate, it must comply

with the requirements of the federal law. *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006); *Frew v. Hawkins*, 540 U.S. 431, 433 (2004); *Atkins v. Rivera*, 477 U.S. 154, 156-57 (1986). The federal government may penalize a state's non-compliance by a reduction or the complete withholding of federal funding to the state. 42 U.S.C. § 1396c (2006); *see also* 42 C.F.R. § 433.140(a)(1) (2012) (applies specifically to a state's failure to seek reimbursement from liable third party).[1]

Medicaid is "the primary federal program for providing medical care to indigents at public expense." *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 262 n.19 (1974). "Medicaid is intended to be the payer of last resort" for needy individuals. S. Rep. No. 99-146, at 279 (1985), as reprinted in 1986 U.S.C.C.A.N. 42, at 312. All "other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." *Id.*

---

[1] Petitioner does not concede that Respondent has a private cause of action through which she may enforce the anti-lien provision of the Medicaid Act. Petitioner did not press that issue below or seek certiorari on that issue, however, and is not asking the Court to resolve the case on that ground. *See Owasso Indep. Sch. Dist. No. I-011 v. Falvo*, 534 U.S. 426, 430-31 (2002) (leaving open question whether the Family Educational Rights and Privacy Act of 1974 is privately enforceable under § 1983). For a discussion as to why there is no private right of action here see Amicus Brief of Texas *et al.*

Accordingly, applicants may obtain Medicaid benefits only if their income and resources are "insufficient to meet the cost of necessary medical services." 42 U.S.C. § 1396-1 (2006). If payment from identified, verified third parties (such as insurance policies) that are probably liable is available at the time a claim is filed, those resources must first be exhausted before a medical provider can be paid by Medicaid. 42 C.F.R. § 433.139(b)(1) (2012).

B. The Third-Party Assignment and Recovery Provisions and the Anti-Lien Provision of the Medicaid Act.

States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for a recipient's medical care, 42 U.S.C. § 1396a(a)(25)(A), and, when such liability is found to exist, to seek reimbursement for such assistance to the extent of such legal liability. 42 U.S.C. § 1396a(a)(25)(B) (2006). The state is then required to return the federal share of the proceeds, which is determined by the matching formula in effect at the time the Medicaid program paid for the medical services, to the Centers for Medicare and Medicaid Services ("CMS"). *See* N.C. Gen. Stat. § 108A-57(a) (2011); 42 U.S.C. § 1396k(b) (2006). The remainder is retained by the state Medicaid program to be used to fund additional Medicaid services. In its last five fiscal years, North Carolina has returned to the federal government annual amounts ranging from $9.7 million to $17.0 million from its third-party recoveries for the

provision of medical services. *See North Carolina Quarterly Medicaid Assistance Expenditures For the Medical Assistance Program, Form CMS 64 Certification*, Quarter Ending 06/30/2012.

The state must accomplish its duties by requiring Medicaid beneficiaries to assign to the state their rights to third-party recoveries for medical expenses. 42 U.S.C. § 1396k (2006). (Pet. App. 120a-122a) These provisions are collectively known as the third-party recovery requirements. A third party is defined as any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State Plan. 42 C.F.R. § 433.136 (2012).

A separate provision of the Act, which is commonly referred to as the "anti-lien provision," protects a Medicaid recipient's property during her lifetime from liens related to medical expenditures made under the Medicaid program. 42 U.S.C. § 1396p(a)(1) (2006). In relevant part, this provision provides that "[n]o lien may be imposed against the property of any individual prior to [her] death on account of medical assistance paid or to be paid on [her] behalf under the State plan." *Id.*

This Court reconciled these two seemingly conflicting provisions in *Ahlborn*, by determining that the third-party recovery provisions are an exception to the anti-lien provision. Since the third-party recovery provisions only require the recovery of reimbursements

for medical services, the anti-lien provision does not allow the state to recover its Medicaid expenditures from proceeds that comprise damages for items other than medical care. *Ahlborn*, 547 U.S. at 284-85. Neither the Medicaid Act, nor the decision in *Ahlborn*, however, specifies how a state should determine what portion of the damages in a personal injury settlement represents reimbursement for medical expenses.

C. North Carolina Has Implemented a Third-Party Recovery Program as Required by Federal Medicaid Law.

North Carolina has complied with its federally approved State Plan for Medical Assistance by enacting an assignment statute at N.C. Gen. Stat. § 108A-59, and a subrogation statute at N.C. Gen. Stat. § 108A-57. The assignment statute provides, as a condition of eligibility, that Medicaid recipients are "deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise, to which [the recipient] may be entitled." N.C. Gen. Stat. § 108A-59(a) (2011) (Pet. App. 116a). Implementation of the recipient's statutory assignment is governed by N.C. Gen. Stat. § 108A-57(a) (2011) (Pet. App. 114a-115a), which requires the attorney for the recipient to enforce the Medicaid program's subrogation rights. The amount of the Medicaid program's subrogated recovery is the lesser of one-third of the gross amount recovered from the third party or the amount paid by the Medicaid program for medical assistance to the recipient.

North Carolina's statutes therefore designate in advance an allocation of settlement proceeds between medical costs and other damages while capping the State's reimbursement at one-third of the total recovery even if the actual Medicaid payment for medical expenses is far greater.

D. Factual Background and Procedural History.

E.M.A. suffered severe injuries at birth resulting in a diagnosis of cerebral palsy with profound physical disabilities. (J.A. 14, ¶22) E.M.A.'s injuries allegedly resulted from the negligence of the medical professionals who attended to her delivery.

E.M.A.'s mother, Sandra Armstrong, applied to the Petitioner Department of Health and Human Services for Medicaid services on E.M.A.'s behalf on April 26, 2000. Pursuant to North Carolina law, she signed an application form which stated in part, that, as a condition of accepting medical assistance, she "agreed to give back to the State any and all money that is received by me or anyone listed on the application . . . for payment of medical and/or hospital bills for which the Medical Assistance program has or will make payment." (Pet. App. 6a; J.A. 30, ¶2)

As a result of her injuries, E.M.A. received medical treatment resulting in payments by DHHS in excess of $1.9 million. (J.A. 14, ¶23) All of the State's payments "were for the cost of the minor Plaintiff's medical care

as a result of the injuries she suffered at her birth." (J.A. 15, ¶24)

1. State court tort action and settlement.

E.M.A.'s guardian *ad litem* and her parents filed a personal injury lawsuit in February 2003 against E.M.A.'s medical care providers for malpractice. The plaintiffs sought compensatory damages resulting from defendants' negligence. The state court complaint alleged that as a proximate result of such negligence "[s]ubstantial medical and life care expenses have been incurred and will continue to be incurred." (J.A. 64, ¶¶45 and 46)

In preparation for settlement negotiations in the state court litigation, counsel for E.M.A.'s guardian *ad litem* and parents was advised by DHHS that, as of September 2006, the Medicaid program had expended in excess of $1.9 million in public funds for medical care directly related to the injuries E.M.A. sustained at her birth. (J.A. 33, ¶¶20, 23, 24) Under North Carolina law, any attorney retained by the beneficiary who has notice of Medicaid payments has a duty to enforce the State's right of recovery. N.C. Gen. Stat. § 108A-57(a).

The plaintiffs settled their medical malpractice action for a lump sum payment, which was not allocated as to different types of damages. A hearing to approve the settlement was held November 13, 2006

in state court. (J.A. 17, ¶34; J.A. 119-20) Because the amount of the State's payments for medical services exceeded one-third of the total recovery, the state court determined the maximum potential amount of the lien pursuant to N.C. Gen. Stat. § 108A-57 was $933,333.33, and ordered that amount to be held in escrow by the county clerk of court until the actual amount of the lien owed to DHHS could be determined. (J.A. 87, ¶13; J.A. 17, ¶35)

On November 14, 2006, the state court entered its order approving the settlement between the parties to the medical malpractice action, which provided that the settlement schedule specifying the dollar amounts implementing the settlement shall be filed under seal. (J.A.78-90) The order approving settlement provided that plaintiffs would waive and relinquish all claims against defendants and directed plaintiffs to file a dismissal with prejudice as to defendants upon payment of the agreed upon amounts. (J.A. 88, ¶¶14 and 15)

The state court order approving the settlement also established an Irrevocable Special Needs Trust for E.M.A. which allowed E.M.A. to receive her portion of the settlement proceeds while still maintaining Medicaid eligibility for her future medical expenses. (J.A. 85, ¶5) Because the trust was established in accordance with 42 U.S.C. § 1396p(d)(4)(A), E.M.A. remains eligible for Medicaid benefits and the State has continued to pay substantial amounts for her on-going medical care. E.M.A. is qualified to receive

Medicaid as a result of her continued need for skilled nursing care and therapy. (J.A. 14, ¶22)

In December 2006, DHHS moved to intervene in the state court medical negligence litigation seeking disbursement of the escrowed funds. (J.A. 19-20, ¶44) A hearing was scheduled for March 27, 2007; however, on March 23, 2007 the guardian *ad litem* for E.M.A. filed a complaint for declaratory judgment in the United States District Court for the Western District of North Carolina. At the March 27, 2007 hearing, the state court denied the State's motion to intervene in the medical negligence action finding that the November 2006 order approving the minor settlement had fully discharged all defendants. The court permitted Respondents to dismiss the action, with the funds available to satisfy the Medicaid lien remaining in escrow.[2]

---

[2] On September 24, 2007, DHHS filed a state court complaint pursuant to N.C. Gen. Stat. § 1-508 seeking review of the superior court's order and distribution of the medical negligence settlement funds held by the Catawba County Clerk of Court. Respondents moved to abate the lawsuit because of the prior pending federal court case arising out of the same subject matter. The state trial judge denied the motion finding that the federal declaratory judgment action involved substantially different parties and issues. On appeal, the North Carolina Court of Appeals reversed. *N.C. Dept. of Health and Human Servs. v. Armstrong*, 690 S.E.2d 293 (N.C. Ct. App. 2010).

2. Litigation in the district court.

The federal complaint, filed on behalf of E.M.A. in the Western District of North Carolina, alleged that N.C. Gen. Stat. §§ 108A-57 and 108A-59 ("the North Carolina Medicaid third-party recovery statutes") violate 42 U.S.C. § 1396p (the federal "Medicaid anti-lien law") and are unconstitutional to the extent they allow the Medicaid program to assert a lien on compensation for damages other than medical expenses. The complaint requested that the State Medicaid program be enjoined from asserting a lien on the minor plaintiff's proceeds. (J.A. 25, ¶3) The federal complaint was subsequently amended to add E.M.A.'s parents, Sandra and William Armstrong, as additional parties. (J.A. 12, ¶11)

The district court stayed the action awaiting a decision in a pending case by the North Carolina Supreme Court, *Andrews v. Haygood*, 362 N.C. 599, 669 S.E.2d 310 (2008), *cert. denied sub nom. Brown v. N.C. Dep't of Health and Human Servs.*, 129 S. Ct. 2792 (2009) (Pet. App. 86a-113a). On December 12, 2008, the North Carolina Supreme Court upheld the State's statutory procedure, ruling that it was consistent with the Medicaid Act's anti-lien law as construed in *Ahlborn*. The court in *Andrews* concluded that the North Carolina law provides a reasonable method for determining "the medical expense portion of a settlement," one that "protects [the recipient's] interests while promoting efficiency in Medicaid

reimbursement cases throughout North Carolina." (Pet. App. 95a)

On June 28, 2010, the district court granted summary judgment in favor of DHHS holding that the North Carolina third-party liability provisions are consistent with the Medicaid Act's anti-lien provisions as construed in *Ahlborn*. (Pet. App. 71a-85a) The district court found that the "Arkansas reimbursement statute [in *Ahlborn*] violated the federal anti-lien provision because it permitted the State to impose a lien beyond the portion of a settlement allocated to medical care." (Pet. App. 82a) By contrast, the district court declared that the North Carolina statute "provides a means of calculating that portion, and then forbids the State from imposing a lien on the remainder of the settlement." (Pet. App. 82a) The district court found the decision of the North Carolina Supreme Court in *Andrews* persuasive, noting that North Carolina's statute prevents a Medicaid recipient from suffering an "excessive depletion of a plaintiff's recovery to satisfy the State's reimbursement lien" because the recovery is capped at one-third of the total recovery. (Pet. App. 82a-83a)

3. The Fourth Circuit's decision.

The United States Court of Appeals for the Fourth Circuit vacated the judgment of the district court. The court held that North Carolina's statutory allocation and cap on the State's recovery does not comport with *Ahlborn* because "it permits DHHS to assert a lien

against settlement proceeds intended (or otherwise properly allocable) to compensate the Medicaid recipient for other claims, such as pain and suffering or lost wages (i.e., in cases where one-third of the recipient's total settlement recovery is greater than the amount DHHS expended on the recipient's behalf)."[3] (Pet. App. 42a) The court ruled that N.C. Gen. Stat. § 108A-57(a) could not be upheld as a special rule or procedure for allocating tort settlements, (Pet. App. 52a), and also found that North Carolina's statutory lien conflicted with the relevant guidance published by the CMS.

The Fourth Circuit concluded that the amount of a recovery that is allocable to medical expenses must be determined pursuant to an adversarial proceeding that affords the Medicaid recipient an opportunity to rebut the statutory presumption. (Pet. App. 53a) The court therefore vacated the decision of the district court and remanded for an evidentiary hearing to

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[3] The Fourth Circuit misstates North Carolina law, which provides that the Medicaid lien is the lesser of the amount of assistance paid by DHHS on behalf of the recipient or one-third of the recovery. N.C. Gen. Stat. § 108A-57. The statutory lien would never result in a recovery of more than the amount DHHS expended on medical services for the recipient even if one-third of the recovery exceeds the amount expended by DHHS. The Fourth Circuit did not repeat this misstatement elsewhere in its opinion, and it does not appear to have been the basis for its holding.

determine the proper amount of DHHS's Medicaid lien. (Pet. App. 55a)

SUMMARY OF ARGUMENT

North Carolina's third-party recovery statutes are not preempted by the Medicaid Act's anti-lien provision because they define the amount of a damage award representing compensation for past medical expenses and then preclude the State from imposing a lien on the remainder of the settlement. Neither the Medicaid Act nor the *Ahlborn* decision specify how a state should determine what portion of a settlement constitutes reimbursement for medical expenses. And North Carolina's third-party recovery procedures have been expressly approved by the CMS, the agency charged with administering the Medicaid program.

North Carolina's procedure apportions in advance of settlement or judgment by a Medicaid recipient the medical services component of any damage recovery. The statutory provisions provide a fair and efficient process for allocating tort settlements that is consistent with the State's long-standing statutory history of apportioning damage recoveries to protect the claims of medical care providers.

Only the State can decide whether to reduce or compromise its Medicaid lien. Allowing the parties to a tort action to structure a settlement so as to minimize the component attributable to medical expenses previously paid by Medicaid is contrary to

the intent of the relevant federal and state statutes mandating the recovery of third-party payments as well as to the fundamental status of Medicaid as the payer of last resort. Nor will a post-settlement, "true value" hearing as contemplated by the Fourth Circuit's decision result in a fair and objective evaluation of the State's entitlement to reimbursement pursuant to its Medicaid lien. There is no "true value" when a personal injury lawsuit is settled; it is ultimately worth what the defendants will pay to be released from liability and what the plaintiffs will accept to dismiss their action.

The State cannot meaningfully participate at such a proceeding because it has no knowledge as to why the parties arrived at the precise set lement figure they did and also has no access to the assessments and considerations that motivated the decision. And the post-settlement hearing will entail presentation of liability and damage evidence from experts, imposing significant litigation costs and burdens on both the recipient and the State.

North Carolina's statutory allocation provisions obviate the need for a "true value" hearing because the parties have full knowledge in advance of any negotiated settlement of the amount of the State's medical service expenditures. The Medicaid lien component must necessarily become part of the settlement calculus. Conducting a post-settlement "true value" hearing would allow the parties to offer self-serving statements as to the structure of their

settlement. The State would have no knowledge or other basis to challenge such statements.

ARGUMENT

NORTH CAROLINA'S THIRD-PARTY RECOVERY STATUTES ARE NOT PREEMPTED BECAUSE THE MEDICAID ACT DOES NOT DIRECT HOW SETTLEMENTS MUST BE APPORTIONED.

In *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), this Court interpreted the Medicaid Act in the context of a state's attempt to claim the majority of the proceeds of a settlement between a Medicaid recipient and the tortfeasor. Arkansas, in its capacity as a party to a federal court declaratory judgment action, had stipulated that only one sixth of the settlement proceeds represented payments for medical expenses, but it sought recovery of its entire Medicaid payment. This Court held that the anti-lien provisions, when read in conjunction with the third-party reimbursement provisions, permitted Arkansas to recover only the portion of the settlement proceeds that properly represented medical expenses.

The Medicaid Act, however, does not regulate how a state should determine what portion of a personal injury damage settlement represents reimbursement for medical expenses. This Court in *Ahlborn* did not supply the absent regulation consistent with the

longstanding doctrine that "[t]o supply omissions transcends the judicial function." *W. Va. Univ. Hosps., Inc. v Casey*, 499 U.S. 83, 101 (1991) (citations omitted). North Carolina's third-party recovery statutes are not preempted by the Medicaid Act's anti-lien provision because they define the amount of a damage award representing compensation for past medical expenses and then preclude the state from imposing a lien on the remainder of the settlement. Nothing in the Medicaid Act overrides the states' longstanding power to regulate tort actions in that manner.

A. The Medicaid Act Leaves to the States the Determination of What Portion of Damages Recovered from a Third Party is Properly Allocable to Medical Expenses.

Ahlborn was limited to the narrow issue of whether Arkansas could recover its Medicaid expenditures from the portion of a settlement that all parties, including the State, agreed represented compensation for matters separate from medical costs. *Ahlborn* did not attempt to define how to identify the portion of a recovery that represents reimbursement for medical expenses. Because of the controlling stipulations, the Court had no reason to address any particular method for determining how much of a settlement, in the absence of a stipulation, represents payment for medical expenses.

Ahlborn did not preclude a state's ability to statutorily assert its priority to recover monies appropriately attributable to medical expenses as a part of the settlement process. As shown below, a state law such as North Carolina's, which establishes in advance rules for how settlement recoveries are allocated, is consistent with the Medicaid Act, including its anti-lien provision.

1. State procedures for allocating tort settlements by Medicaid recipients are not precluded by the anti-lien provision.

A state's ability to allocate a recipient's tort settlement necessarily follows from the forced assignment requirement of the Medicaid Act. Without the ability to protect its lien for Medicaid expenditures, the state would only be able to recover the amount the recipient claims represents third-party compensation for past medical expenses. The anti-lien provision, however, does not give recipients that power to undermine the Act's third-party recovery provisions.

Ahlborn found that the Medicaid Act's "third-party liability provisions *require* an assignment" of the right to recover that portion of a settlement that represents payment for medical care, 547 U.S. at 282, declaring "[t]here is no question that the State can require an assignment" of a Medicaid recipient's right to receive payments for medical care, and that the State's prerogative is "expressly provided" for in the third-

party recovery provisions of the Medicaid Act. *Id.* at 284. This Court concluded that "[t]o the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision." *Id.*

However, neither the Medicaid Act nor *Ahlborn* specifies how a state should determine what portion of a personal injury damage settlement represents reimbursement for medical expenses. *Ahlborn* recognized that states may have "special rules and procedures for allocating tort settlements," but ultimately "express[ed] no view on the matter" and "le[ft] open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation." *Id.* at 288 n.18.

The determination of how to allocate damages in a tort claim action has been left to the states. As Justice Ginsburg recognized in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 2632 (2012):

> [a]ny fair appraisal of Medicaid would require acknowledgment of the considerable autonomy States enjoy under the Act. . . . Subject to its basic requirements, the Medicaid Act empowers States to select dramatically different levels of funding and coverage, alter and experiment with different financing and delivery modes, and opt to cover (or not to cover) a range of particular procedures and

> therapies. States have leveraged this policy discretion to generate a myriad of dramatically different Medicaid programs over the past several decades.

(Ginsburg, J., concurring in part, concurring in the judgment in part and dissenting in part) (citations omitted). As discussed in Section (A)2., *infra*, determining the rules that apply to tort actions, including the allocation of damage recoveries, is one of those powers that Medicaid leaves to the states.

North Carolina's Medicaid lien statute reflects a proper exercise of the legislative prerogative where federal law provides no procedure for states to employ in furtherance of their third-party recovery obligation. The statutory formula provides a fair, certain and effective solution that balances the recovery of taxpayer monies paid for necessary medical care with the individual needs of a recipient who has been injured by the negligence of a third party. North Carolina's statute cannot be said to conflict with federal law regulating how to allocate settlements, when there is no such federal law.

2. States have traditionally exercised broad authority over tort actions, including the amount of damages that a party may recover.

The Medicaid Act's provisions regarding recoveries from third-party tortfeasors (or their insurance

companies) operate within the context of a tort system that is largely governed by state law. States have longstanding control over the parameters of tort actions, including the regulation of issues regarding the scope of damages that may be recovered. Indeed, it has been observed that "the provision of tort remedies to compensate for personal injuries . . . [is] within the scope of the States' historic police powers." *Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 894 (2000) (Stevens, J., dissenting).

A state can allow or disallow certain types of claims (*e.g.*, pain and suffering; loss of consortium; emotional distress; lost wages and earning capacity); a state can have a contributory negligence rule or a comparative negligence rule; it can have various assumption of risk rules; it can impose caps on certain types of recoveries; and it can bar claims not brought within the requisite time set forth in a statute of limitations. A state has authority to adopt tort rules declaring, for example, that punitive damages or pain-and-suffering damages may not exceed a certain amount. A plaintiff therefore has no absolute entitlement, separate and apart from what state law allows, to recover any particular amount for any particular type of damages.

In North Carolina, the statutory allocation of Medicaid settlements is reinforced by the broad range of the General Assembly's enactments regulating various aspects of tort actions. For example, legislation governs how damages are allocated when

two or more persons become jointly or severally liable in tort for the same injury pursuant to the "Uniform Contribution Among Tort-Feasors Act," N.C. Gen. Stat. § 1B-1, *et seq.* (2011). Punitive damages are capped at $250,000 or three times the amount of compensatory damages by N.C. Gen. Stat. § 1D-25. Noneconomic damages in medical malpractice actions are capped at $500,000 by N.C. Gen. Stat. § 90-21.19. And tort claims against the State are barred unless brought within three years after accrual, N.C. Gen. Stat. § 143-299, with the maximum amount that the State can be made to pay cumulatively to all claimants arising out of any one occurrence capped at $1,000,000. N.C. Gen. Stat. § 143-299.2 (2011).

The North Carolina Medicaid third-party recovery statutes at issue are part and parcel of the State's longstanding exercise of its power to oversee tort actions. North Carolina has specifically recognized a statutory medical lien on proceeds of tort settlements for over 70 years. This medical lien, which predates the existence of the Medicaid program, applies when injured persons have obligations for medical bills at the time of judgment or settlement.

Tracing back to legislation first adopted in 1935, N.C. Gen. Stat. § 44-49 creates a "lien upon any sums recovered as damages for personal injury in any civil action in this State" for providers of medical supplies or services. (App. 1-2) N.C. Gen. Stat. § 44-50 further provides that such lien "shall also attach upon all funds paid to any person in compensation for or

settlement of the injuries, whether in litigation or otherwise," and specifies an allocation formula under which "[t]he lien provided for shall, in no case, exclusive of attorneys' fees, exceed fifty percent (50%) of the amount of damages recovered."[4] (App. 3-4) Thus, the concepts and policy considerations underlying the statutory formula contained in N.C. Gen. Stat. § 108A-57 are not unique to settlements involving Medicaid recipients; instead, they are wholly consistent with North Carolina's long-standing statutory allocation of tort settlements to protect the providers of medical supplies and services.

3. North Carolina's statutes apportion, in advance of a settlement or judgment, the medical services portion of any recovery of damages.

As previously discussed, *Ahlborn* recognized that states may have "special rules and procedures for allocating tort settlements," but ultimately "express[ed] no view on the matter" and "le[ft] open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation." *Id.* at 288 n.18. And while noting that the issue was not squarely before it, this Court

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[4] In the situation where attorney's fees are set at 33%, the medical services lien formula for non-Medicaid recipients is the functional equivalent of the lien formula set out in N.C. Gen. Stat. § 108A-57 applicable to Medicaid recipients.

acknowledged that one way to avoid manipulation of a settlement so as to "allocate away the State's interest" was to obtain "the State's advance agreement to an allocation." *Id.* at 288.

North Carolina's statutes utilize both approaches addressed by *Ahlborn*: they establish criteria regarding how tort settlements are to be allocated when the Medicaid program has paid a recipient's medical expenses and they provide an advance agreement that the State will reduce its lien if the amount of the Medicaid lien exceeds one-third of the total recovery. North Carolina law does this by requiring a recipient's attorney who has actual notice of payments made on behalf of the recipient to enforce the Medicaid program's subrogation rights. N.C. Gen. Stat. § 108A-57.

Thus, before a settlement is ever reached, the recipient's attorney is aware of the precise amount that must be allocated to satisfy the Medicaid lien; the Medicaid lien is, necessarily, a part of the settlement negotiations. There is no possibility that the parties could be uncertain as to the amount that represents reimbursement for medical expenses. The parties must allocate the settlement in conformity with the statute. Furthermore, because the parties to the settlement agreement know in advance what the medical expenses portion of any settlement will be, the recipient can fully and accurately evaluate any settlement offer.

North Carolina law recognizes that an injured recipient has suffered cognizable damages other than medical damages. As an incentive for the recipient to pursue the action, and, as compensation for her non-medical damages, North Carolina law shields a substantial portion of the recipient's recovery from the Medicaid lien. The Medicaid lien is limited to the amount paid by Medicaid, not to exceed one-third of the settlement even if the actual Medicaid payment for medical expenses is far greater and even if future Medicaid expenses for the recipient are expected to be substantial. This ensures that the recipient has access to the majority of the proceeds to pay attorneys fees and costs as well as to apply to categories of damages other than medical expenses.

The statutory formula also guarantees that, if the case has weaknesses, or if the tortfeasor has limited funds, or if, for any other reason, the case must be settled for cents on the dollar, the Medicaid lien is automatically compromised in order to ensure that the recipient still retains the greater portion of the settlement to apply to her litigation costs and non-medical damages.

Thus, the recipient retains full discretion to compromise her claims but has no legal basis to unilaterally foreclose the Medicaid lien by omitting or understating the medical damages. The amount which will go to Medicaid is set by statute. The Medicaid lien is part of the fabric of the settlement. Irrespective of whether the parties to a settlement purport to

"designate" the amount of the medicals or not, the Medicaid lien is protected since it is established and defined by statute.

As recognized by the district court below, North Carolina's statute "provides a means of calculating that portion [of a settlement representing payment for medical expenses], and then forbids the State from imposing a lien on the remainder of the settlement." (Pet. App. 82a) As such, the statute "protects [Medicaid recipients'] interests while promoting efficiency in Medicaid reimbursement cases throughout North Carolina." (Pet. App. 79a-80a) And, as recognized by the North Carolina Supreme Court in *Andrews*, "[w]eighing these and other public policy considerations is the province of our General Assembly." (Pet. App. 96a)

B. The Fourth Circuit Erred in Holding That There is a "True Value" of Tort Claims that Can, and Must, Be Determined through Evidentiary Hearings or the Parties' Designation.

As previously shown, the parameters of tort recoveries are governed by state law, including the amount of damages that may be recovered. The decision of the Fourth Circuit suggests, however, that irrespective of the amount of a settlement reached by the parties, there is an ascertainable "true value" of the case that should control what portion of any settlement is subject to the State's third-party recovery

rights. However, a post-settlement hearing will be burdensome to both the Medicaid recipient and the State while not establishing a bona fide "true value" from which to allocate a tort settlement.

1. A post-settlement "true value" hearing, as required by the Fourth Circuit, is untenable.

The Fourth Circuit erred by reading into *Ahlborn* a requirement that a hearing "must determine the true value of the case," (Pet. App. 50a), and that the amount of North Carolina's statutory lien "must be subject to adversarial testing" (Pet. App. 53a). *Ahlborn* did not hold that a post-settlement hearing must be conducted to allocate damages. In response to concerns expressed by Arkansas and the United States that private litigants might manipulate settlement allocations, this Court observed that such a risk can be avoided either by obtaining the state's advance agreement to an allocation or, "if necessary, by submitting the matter to a court for decision." *Ahlborn*, 547 U.S. at 288. This mere suggestion of a court review does not support the Fourth Circuit's requirement for an evidentiary hearing to establish what portion of the settlement proceeds are "properly allocable to past medical expenses." (Pet. App. 54a) *Ahlborn* held nothing of the sort, and other language in the opinion leaving open the possible adoption of special rules and procedures confirms that states have other available options that are consistent with the Medicaid Act.

Nor would it make sense to require such hearings. There is no objective "true value" of a case that can be divined by post-settlement analysis. Necessarily, settlements reflect subjective and individualized considerations that prompt plaintiffs to forgo trials. Even if a judge holds a full-blown post-settlement hearing to determine what damages the plaintiff could have recovered if the case had gone to trial, that does not inform the question of what portion of which category of damages the jury would have accepted and to what extent so as to establish a hypothetical "true value." Nor is there any realistic basis for determining what portions of the settlement are properly allocable to different types of damages when parties settle for less than the asserted amount of their claim.

Furthermore, any post-settlement "true value" hearing would be wasteful, time consuming, and costly for both the state and the plaintiff. Parties settle tort actions in large part to spare themselves the large expenses of a trial. Yet the Fourth Circuit rule would require frequent mini-trials that could amount to proceedings as involved and costly as a trial itself. Liability theories and defenses would have to be addressed and expert testimony would be required on the various components of damages.

The state would necessarily be at a decided disadvantage at any post-settlement hearing, without critically-important knowledge essential to assess any "true value" of the case as well as the reasons why the parties arrived at the precise settlement figure they

did. The state comes to the case only with its proof of damages and no independent proof of liability, being largely, if not entirely dependent upon the recipient for that evidence. Meaningful participation by the state would require access to the parties' privileged settlement assessments and communications as well as to information protected by the attorney-client privilege.

The post-settlement "true value" hearing contemplated by the Fourth Circuit would be necessary in most cases but would not result in a fair or objective evaluation of the State's Medicaid lien. Experience shows that the vast majority of tort actions settle. Data from 2005 analyzed by the Bureau of Justice Statistics found that only 4% of all tort dispositions resulted from bench and jury trials. Thomas H. Cohen, Bureau of Justice Statistics, *Tort Bench and Jury Trials in State Courts, 2005* (2009) at 1. Additionally, another study indicated that "[a]bout 95% of medical malpractice insurance claims settled prior to trial." Thomas H. Cohen & Kristen A. Hughes, Bureau of Justice Statistics, *Medical Malpractice Insurance Claims in Seven States, 2000-2004* (2007) at 7.

North Carolina's statutory allocation provision obviates the need for a "true value" hearing because the amount of the State's lien for past medical service payments is known in advance of any settlement negotiations, and the statutory formula allows a precise determination by the recipient as to the portion

of any settlement to be repaid to the State. A post-settlement proceeding built around self-serving testimony on behalf of a plaintiff as to how a settlement was structured, for which the State would have virtually no basis to challenge, would substantially undercut the State's ability to enforce its third-party recovery rights.

2. A recipient's designation of the amount of damages attributable to past medical expenses inadequately protects the State's lien.

A Medicaid recipient has no right to reduce her reimbursement obligation because the recovery was less than the full amount of her damages. The reimbursement lien is part of a quid pro quo for her immediate access to medical care even though a third party was responsible for her injuries. Allowing either a binding designation by the plaintiff or applying a pro rata reduction to the medical damages component of a damage recovery would transfer control over the State's lien to the recipient.

The Fourth Circuit opinion takes out of context language from *Ahlborn* when it declares that state laws are prohibited if they "permit recovery over and above what the parties have appropriately designated as payment for medical items and services." (Pet. App. 46a) *Ahlborn* found that Arkansas, as a party to the federal court declaratory judgment action brought by the recipient, had conclusively stipulated to the

portion of the settlement proceeds that were "properly . . . *designated* as payments for medical costs." 547 U.S. at 288 (emphasis added). In proper context, the use of the word "designated" refers to the agreed stipulation and offers no support for the contention that a plaintiff and a tortfeasor have the power to "designate" which portion (if any) of a settlement is recoverable as reimbursement for the payment of past medical expenses by a state that has not agreed to such designation.

Plainly, there is an incentive for the recipient to allocate claims artificially to other categories other than past medical expenses in order to benefit at the expense of the state. Indeed, both plaintiff and defendant have an interest in minimizing the amount the plaintiff has to pay out to the state in satisfaction of the Medicaid lien. It defies common sense to allow a plaintiff to control the self-interested allocation that would place the state in the position of challenging a personal injury attorney's estimate of the amount of damages recoverable and diminishes the likelihood of achieving any such recovery.

Nor can use of a simplistic "proportional analysis" resulting in a pro rata reduction of the medical lien when the settlement does not fully compensate for the "true value" of the case withstand analysis. (Pet. App. 50a) Evidence regarding medical damages is stronger than many other elements of a tort recovery; they are easily reduced to dollar amounts; they do not entail speculation and they are not easy to manipulate or

exaggerate. Thus, although other damages may be discounted because they are difficult to prove or speculative, there is no logic in reducing the medical damages in the same proportion. Furthermore, medical bills are an obligation and a priority that must be addressed even if that means that the recipient is not made whole on all other damages. Not all damages have equal weight.

Additionally, application of a pro rata reduction theory to funds recovered in settlement with third parties would create opportunities for manipulation of the amount apportioned for different types of damages. That is, the more the recipient is able to inflate her claim for non-medical damages, the more the recipient would be able to keep and the less Medicaid would receive in reimbursement. Any suggestion that recipients will not manipulate their hypothetical total damages, but will, instead, recognize a personal responsibility to repay the Medicaid program is belied by the facts of this case where the recipient accepted almost two million dollars of services paid for by taxpayers and then sought to deny the Medicaid program even a single dollar of the $2.8 million dollar settlement.

While the Fourth Circuit indicated its rejection that a "proportional analysis" was appropriate, it remanded the case with instructions for the district court to find the "true value" of the case. (Pet. App. 50a) The decision then cited with approval language in *Price v. Wolford*, 608 F.3d 698, 707-08 (10th Cir.

2010), that could support a proportional reduction in the Medicaid lien on the grounds that liability is uncertain or on the grounds that the defendant is unable to pay any more. (Pet. App. 50a-51a n.12) The Fourth Circuit characterized *Wolford* as having "helpfully indicated the kind of considerations that might be salient in assessing the propriety of a particular lien determination," noting that "[t]he usual reasons [for paying less than the full amount of the Medicaid lien] would be that the liability of the settling defendant is uncertain or that the defendant lacks the money to pay for his full liability (or both)." (Pet. App. 50a-51a n12) As such, the opinion inappropriately suggests the utilization of a proportional analysis as part of the "true value" determination.

It would be irrational to allow a recipient to structure a settlement in such a way as to reflect minimal compensation for medical expenses. And utilization of a pro rata formula would similarly force the State to bear the financial consequences of her actions contrary to the intent of the relevant federal and state statutes.

C. North Carolina's Third-Party Recovery Procedure Operates with the Knowledge of and the Approval of the Centers for Medicare & Medicaid Services.

The Centers for Medicare and Medicaid Services ("CMS"), which is a branch of the Department of Health and Human Services, administers the Medicaid program. *Douglas v. Indep. Living Ctr. of S. Cal.*, 132 S. Ct. 1204, 1205 (2012). This Court has recognized Congress's "extremely broad [delegation of] regulatory authority to the Secretary in the Medicaid area." *Ahlborn*, 547 U.S. at 292 (citing *Wis. Dept. of Health & Family Servs. v. Blumer*, 534 U.S. 473, 497 n.13 (2002) (citations omitted)).

CMS is mandated by 42 U.S.C. § 1396(a)(25)(A)(ii) to monitor, on an ongoing basis, a state's plan for pursuing third parties. CMS is aware of North Carolina's statutory methodology for allocating damages and has specifically declared that North Carolina's statute comports with the anti-lien provision as it was construed in *Ahlborn*. CMS maintains that North Carolina's statutes are consistent with the Medicaid Act and specifically approved the analysis of North Carolina's procedures in the State Supreme Court decision in *Andrews*. *See* December 23, 2009, Reply Memo of the Centers for Medicare & Medicaid Services to [North Carolina Congressman] Howard Coble. (Pet. App. 139a-142a)

The Fourth Circuit cited a July 3, 2006 CMS Memorandum, "State Options for Recovery Against Liability Settlements in Light of U.S. Supreme Court Decision in *Arkansas Department of Human Services v. Ahlborn*," Centers for Medicare & Medicaid Services ("CMS Memorandum") (Pet. App. 124a-138a), as

support for its holding that North Carolina's statute conflicts with the Medicaid Act. (Pet. App. 45a-47a) However, that CMS Memorandum, after delineating the key findings of *Ahlborn*, listed actions that states may take, including (1) "enact laws which provide for a specific allocation amongst damage[s], i.e., pain and suffering, lost wages, and medical claims;" and (2) "require that cases can only be compromised with the consent of the state." (Pet. App. 129a)

The North Carolina third-party recovery statute is a law "provid[ing] for a specific allocation amongst damage[s]" - it provides that up to one-third of a total recovery must be designated as payment for past medical costs. (Pet. App. 47a) Additionally, North Carolina has put in place a law "requir[ing] that cases only be compromised with the consent of the state." (Pet. App. 47a) North Carolina's subrogation statute provides the State's consent to compromise by automatically reducing its lien to one-third of the recovery if the recovery does not equal at least three times the amount of the Medicaid lien. And, as previously shown, CMS has specifically stated that neither the North Carolina statute nor the *Andrews* decision conflicts with the CMS Memorandum. (Pet. App. 139a-142a) Thus, the Fourth Circuit misread and misapplied the relevant CMS guidance.

The Medicaid Act commits to the federal agency the power to administer a federal program. Where the agency has acted under this grant of authority, the decision "carries weight." *Indep. Living Ctr. of S. Cal.*,

Inc., 132 S. Ct. at 1210 ("[O]rdinarily review of agency action requires courts to apply certain standards of deference to agency decisionmaking."). *See Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967 (2005) (describing deference reviewing courts must show); *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984) (same). CMS's approval of North Carolina's processes is entitled to deference.

CONCLUSION

The Judgment of the Court of Appeals for the Fourth Circuit should be reversed.

Respectfully submitted,

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N.C. Gen. Stat. § 44-49 (2012)

CHAPTER 44. LIENS
ARTICLE 9. LIENS UPON RECOVERIES FOR PERSONAL INJURIES TO SECURE SUMS DUE FOR MEDICAL ATTENTION, ETC.

N.C. Gen. Stat. § 44-49 (2012)

§ 44-49. Lien created; applicable to persons non sui juris.

(a) From and after March 26, 1935, there is hereby created a lien upon any sums recovered as damages for personal injury in any civil action in this State. This lien is in favor of any person, corporation, State entity, municipal corporation or county to whom the person so recovering, or the person in whose behalf the recovery has been made, may be indebted for any drugs, medical supplies, ambulance services, services rendered by any physician, dentist, nurse, or hospital, or hospital attention or services rendered in connection with the injury in compensation for which the damages have been recovered. Where damages are recovered for and in behalf of minors or persons non compos mentis, the liens shall attach to the sum recovered as fully as if the person were sui juris.

(b) Notwithstanding subsection (a) of this section, no lien provided for under subsection (a) of this section is valid with respect to any claims whatsoever unless the physician, dentist, nurse, hospital, corporation, or other person entitled to the lien furnishes, without charge to the attorney as a condition precedent to the creation of the lien, upon request to the attorney

representing the person in whose behalf the claim for personal injury is made, an itemized statement, hospital record, or medical report for the use of the attorney in the negotiation, settlement, or trial of the claim arising by reason of the personal injury, and a written notice to the attorney of the lien claimed.

(c) No action shall lie against any clerk of court or any surety on any clerk's bond to recover any claims based upon any lien or liens created under subsection (a) of this section when recovery has been had by the person injured, and no claims against the recovery were filed with the clerk by any person or corporation, and the clerk has otherwise disbursed according to law the money recovered in the action for personal injuries.

HISTORY: 1935, c. 121, s. 1; 1947, c. 1027; 1959, c. 800, s. 1; 1967, c. 1204, s. 1; 1969, c. 450, s. 1; 2001-377, s. 1; 2001-487, s. 59.

N.C. Gen. Stat. § 44-50 (2012)

CHAPTER 44. LIENS
ARTICLE 9. LIENS UPON RECOVERIES FOR PERSONAL INJURIES TO SECURE SUMS DUE FOR MEDICAL ATTENTION, ETC.

N.C. Gen. Stat. § 44-50 (2012)

§ 44-50. Receiving person charged with duty of retaining funds for purpose stated; evidence; attorney's fees; charges.

A lien as provided under G.S. 44-49 shall also attach upon all funds paid to any person in compensation for or settlement of the injuries, whether in litigation or otherwise. If an attorney represents the injured person, the lien is perfected as provided under G.S. 44-49. Before their disbursement, any person that receives those funds shall retain out of any recovery or any compensation so received a sufficient amount to pay the just and bona fide claims for any drugs, medical supplies, ambulance services, services rendered by any physician, dentist, nurse, or hospital, or hospital attention or services, after having received notice of those claims. Evidence as to the amount of the charges shall be competent in the trial of the action. Nothing in this section or in G.S. 44-49 shall be construed so as to interfere with any amount due for attorney's services. The lien provided for shall in no case, exclusive of attorneys' fees, exceed fifty percent (50%) of the amount of damages recovered. Except as provided in G.S. 44-51, a client's instructions for the disbursement of settlement or judgment

proceeds are not binding on the disbursing attorney to the extent that the instructions conflict with the requirements of this Article.

HISTORY: 1935, c. 121, s. 2; 1959, c. 800, s. 2; 1969, c. 450, s. 2; 1995, c. 538, s. 6(b); 1995 (Reg. Sess., 1996), c. 674, s. 3; 2001-377, s. 2.

RESPONDENT'S BRIEF

No. 12-98

In the Supreme Court of the United States

ALBERT A. DELIA, ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

E.M.A. (BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON), WILLIAM EARL ARMSTRONG AND SANDRA ARMSTRONG,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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December 2012

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QUESTION PRESENTED

Does the anti-lien provision of the federal Medicaid laws, 42 U.S.C. § 1396p(a), preempt North Carolina General Statutes Section 108A-57, which purports to create a lien on any tort settlement received by a Medicaid recipient from a third-party up to one-third of the settlement?

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In the Supreme Court of the United States

No. 12-98

ALBERT A. DELIA, ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

E.M.A. (BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON), WILLIAM EARL ARMSTRONG AND SANDRA ARMSTRONG,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR RESPONDENTS

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit (Pet. App. 1a-70a) is reported at 674 F.3d 290. The opinion of the district court (Pet. App. 70a-85a) is reported at 722 F. Supp. 2d 653.

JURISDICTION

The judgment of the United States Court of Appeals for the Fourth Circuit was entered on March 22, 2012. On June 14, 2012, the Chief Justice extended the time to and including July 20, 2012 within which to file the petition for writ of certiorari. The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

Subject matter jurisdiction over the action arises under 28 U.S.C. §§ 1331, 1343(a)(3). *See Verizon Md. Inc. v. Public Serv. Comm'n*, 535 U.S. 635 (2002) (recognizing § 1331 grants subject matter jurisdiction over action seeking declaratory judgment against state agency based on a purported violation of federal law unless the claim is wholly insubstantial and frivolous).

STATUTORY PROVISIONS INVOLVED

This case involves various provisions of the Medicaid Act, 42 U.S.C. §§ 1396 *et seq.* The applicable provisions are set out in the Appendix to this brief at 1a-7a and in the Appendix to the Petition for Writ of Certiorari at 118a-23a.

STATEMENT

1. North Carolina, like all other States, voluntarily participates in the federal Medicaid program. As a result, the State of North Carolina has expressly agreed to be bound by the terms of that federal program. *See, e.g.*, 42 U.S.C. § 1396a; N.C. Gen. Stat. §§ 108A-54, -56.

The federal Medicaid program limits a State's ability to impose a lien on the property of a Medicaid beneficiary. Specifically, the federal anti-lien provision states: "No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan * * * *" 42 U.S.C. § 1396p(a)(1).[1] Additionally, Medicaid's assignment provisions direct that a Medicaid recipient must assign to the state Medicaid program "any rights * * * to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A).

2. Respondent E.M.A. is a twelve year old girl who lives with her parents in Taylorsville, North Carolina. As a result of malpractice by the physician who delivered her at birth, E.M.A. is deaf, blind, and unable to sit, walk, crawl or talk and suffers from mental retardation and a seizure disorder. Pet. App. 5a. Based on her extensive pain and suffering, loss of enjoyment of life, loss of earning capacity and future medical expenses, E.M.A. incurred damages in excess of $42 million as a result of her physician's malpractice. *See* J.A. 91-112.

In February 2003, E.M.A.'s guardian ad litem brought a malpractice action against E.M.A.'s treating physician and others in North Carolina state court. Following the filing of the medical malpractice action, the North Carolina Department

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[1] The anti-lien provision sets out two exceptions – neither of which is applicable here.

of Health and Human Services ("NC DHHS") asserted a statutory lien on any settlement proceeds resulting from that action. NC DHHS based its claim of lien on N.C. Gen. Stat. § 108A-57(a) which provides:

> [T]he State * * * shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance * * * * Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but *the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.*

N.C. Gen. Stat. § 108A-57(a) (emphasis added).

3. On September 27, 2006, a mediated settlement conference was held in E.M.A.'s state tort action. J.A. 17. NC DHHS was notified of the settlement conference but failed to attend. *See, e.g., id.* At the settlement conference, an agreement was reached to settle E.M.A.'s claims for the sum of $2.8

million, subject to court approval.[2] The settlement amount was significantly influenced by considerations of limited available medical malpractice insurance coverage and the challenges generally associated with collecting a judgment from the limited assets of an individual.

Under North Carolina law, a settlement involving a minor or a person who is incompetent is valid only if approved by the court. *See Bunch v. Foreman Blades Lumber Co.*, 93 S.E. 374, 376 (N.C. 1917); *Ballard v. Hunter*, 184 S.E.2d 423, 427 (N.C. Ct. App. 1971). On November 14, 2006, the state superior court judge entered an order approving the settlement. The court concluded that the settlement agreement "is fair and just, is in the best interest of the minor plaintiff [E.M.A.], and is in all respects reasonable and proper." J.A. 80-81. The court's order directs that one-third of the settlement payment (i.e., the sum of $933,333.33) be paid to the Clerk of Court and placed in an interest bearing account "until such time as the actual amount of the lien owed by [E.M.A.] to the North Carolina Division of Medical Assistance is conclusively judicially determined." J.A. 87; *see* Pet. App. 4a.

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[2] When the parties moved for court approval of the settlement, the state superior court judge ordered that the settlement agreement be filed under seal. J.A. 81. Nevertheless, it is possible to reconstruct the amount of the settlement based on the court's order that the sum of $933,333.33 ("the maximum potential amount of the Medicaid lien") be delivered to the clerk of court until the lien is "conclusively judicially determined." J.A. 87; *see* Pet. App. 3a-4a.

Under the superior court's order, the funds released to E.M.A. were placed in a Special Needs Trust. J.A. 85. The Medicaid Act permits the proceeds of a personal injury action to be placed into a Special Needs Trust, but places specific restrictions on such a trust. 42 U.S.C. § 1396p(d)(4)(A). Funds in such a trust may be used only for the sole benefit of the trust beneficiary, including things such as medical equipment and services not provided through Medicaid, attendant care and private rehabilitation services. *See* Soc. Sec. Admin., Program Operations Manual System, SI 01120.200(E)(1)(c), .201(F)(2), .203(B)(1)(e) (available at https://secure.ssa.gov/poms.nsf/). Additionally, the trust must provide that the State will receive all amounts remaining in the trust on the death of the Medicaid beneficiary up to an amount equal to the total medical assistance paid on behalf of the individual. 42 U.S.C. § 1396p(d)(4)(A). Trusts that meet these requirements do not render the trust beneficiary ineligible for Medicaid services. *See id.* The net effect of placing E.M.A.'s settlement funds into a Special Needs Trust is that far greater assets are available to potentially reimburse the State, though the State's right to seek reimbursement from these assets cannot be enforced until E.M.A. passes away.[3]

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[3] Under this Court's decision in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), the lien of the state Medicaid program is limited to the portion of the settlement that is attributable to medical expenses. In contrast, the state Medicaid program can recover all amounts remaining in the Special Needs Trust (up to the total amount of medical assistance paid) on the death of the beneficiary.

The order of the state superior court approving the settlement expressly provides that any portion of the $933,333.33 being held by the clerk of court that is not used to pay the State's lien must be distributed to the E.M.A. Irrevocable Special Needs Trust. J.A. 87.

4. On March 23, 2007, E.M.A. and her parents brought the present action in federal district court, seeking a declaratory judgment that the lien by NC DHHS was preempted by the federal Medicaid Act, 42 U.S.C. § 1396p(a). The complaint alleges that NC DHHS' assertion of a lien is inconsistent with the anti-lien provision of the federal Medicaid laws and this Court's decision in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006). J.A. 18. The complaint prays that the court declare N.C. Gen. Stat. § 108A-57 unconstitutional. J.A. 25. The district court proceeded to stay discovery pending the appeal before the North Carolina Supreme Court in *Andrews v. Haygood*, 57A07-2, which raised similar challenges to the North Carolina statute. Pet. App. 74a. In response to E.M.A.'s complaint, NC DHHS similarly requested that the federal district court adjudicate the interests of the parties with respect to the sum being held by the clerk of court. J.A. 30, 39.

On December 12, 2008, the North Carolina Supreme Court rendered its decision in *Andrews v. Haygood*, 669 S.E.2d 310 (N.C. 2008), *cert. denied*, 557 U.S. 904 (2009). Relying on a presumption that state statutes are constitutional, the North Carolina Supreme Court, in a 4-3 decision, held that N.C. Gen. Stat. § 108A-57 is not preempted by federal

law. 669 S.E.2d at 313-14. The North Carolina Supreme Court distinguished this Court's decision in *Ahlborn* in that the *Ahlborn* decision involved a stipulation by the parties as to the reasonable value of the plaintiff's total claim for damages. *Id.* at 313. ("*Ahlborn* thus controls when there has been a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement.").

In *Andrews*, the North Carolina Supreme Court concluded that N.C. Gen. Stat. § 108A-57 "comports with *Ahlborn* by providing a reasonable method for determining the State's medical reimbursements." 669 S.E.2d at 314. The majority in *Andrews* opined that allowing NC DHHS to take one-third of all tort settlements without having to determine the actual proportion between various categories of damages would "promot[e] efficiency in Medicaid reimbursement." *Id.* Justice Hudson, joined by Justices Brady and Timmons-Goodson, dissented. She reasoned that "*Ahlborn* is binding upon this Court, and its reasoning and holding compel the conclusion that the application of N.C.G.S. § 108A-57(a) here, without any further determination of how the settlement proceeds were allocated among different types of damages alleged by plaintiff, would be contrary to federal law." *Id.* at 316 (Hudson, J., dissenting).

The federal district court below adopted the reasoning of the majority in *Andrews* and granted summary judgment in favor of NC DHHS. Citing footnote 18 of this Court's decision in *Ahlborn*, the district court reasoned that the *Ahlborn* decision leaves open the possibility that a State could

"'adopt[] special rules and procedures for allocating tort settlements.'" Pet. App. 84a (quoting *Ahlborn*, 547 U.S. at 288 n.18). According to the district court, "North Carolina has adopted such a statutory scheme, which provides a reasonable method for ascertaining the State's medical reimbursements, while still protecting the interests of Medicaid recipients * * * *" Pet. App. 84a-85a.

5. The Fourth Circuit reversed the district court, concluding that the irrebuttable presumption created by N.C. Gen. Stat. § 108A-57 is inconsistent with the *Ahlborn* decision. Pet. App. 52a (noting that *Ahlborn* cautions that if state rules and statutes provide a formula for allocating a settlement between medical expenses paid by Medicaid and other categories of damages, States "must afford a mechanism permitting beneficiaries to rebut such a presumption"). The Fourth Circuit noted that "under the circumstances in this case, North Carolina's statutory presumption must be subject to adversarial testing." Pet. App. 53a. The Fourth Circuit concluded "the one-third cap on the state's recovery imposed by the North Carolina third-party liability statutes is in fatal conflict with federal law." Pet. App. 5a.

SUMMARY OF ARGUMENT

The Medicaid Act severely restricts the ability of state Medicaid programs to seize or encumber the property of Medicaid beneficiaries. *See* 42 U.S.C. § 1396p(a)(1). When a Medicaid beneficiary brings a claim against a third-party tortfeasor, the state Medicaid program has no right to claim the portion

of any settlement or award attributable to damages such as pain and suffering, disfigurement or lost wages. *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 280-81 (2006). Rather, the state Medicaid program may assert a claim only with respect to that portion of the settlement or award that is fairly attributable to medical expenses paid by the state Medicaid program. *Id.* In *Ahlborn*, this Court unanimously held that the Medicaid Act unambiguously prohibits States from "lay[ing] claim to more than the portion of [a Medicaid beneficiary's tort] settlement that represents medical expenses." *Id.* at 280.

Despite the clear directive of the Medicaid Act and this Court's unanimous decision in *Ahlborn*, N.C. Gen. Stat. § 108A-57 dictates the sum that the State is allowed to recover from tort settlements, even if that sum is greater than the portion of the settlement representing medical expenses. Specifically, the North Carolina statute provides that to the extent the State has paid Medicaid benefits, the State shall be subrogated to the rights of the Medicaid beneficiary against any third party, "but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered." N.C. Gen. Stat. § 108A-57. The State's one-third minimum recovery applies when a tort victim (such as E.M.A.) is able to recover only a small portion of her overall damages as a result of the tortfeasor not being sufficiently solvent. In such situations, the State ends up taking a third of the settlement even though a fair allocation of the portion of the settlement that represents payment

for medical expenses would be much smaller than one-third of the settlement.

The arbitrary nature of the North Carolina statute is shown by the State's failure to come forward with any explanation as to how the statute constitutes a fair allocation between medical expenses and other damages. In fact, Petitioner has conceded that the purported allocation created by the statute "rests on nothing more than the state's notion of how attorneys and insurance adjusters typically value tort cases." Pet. App. 20a.

The *Ahlborn* decision demonstrates that N.C. Gen. Stat. § 108A-57 is in conflict with Medicaid's anti-lien provision and is therefore unenforceable. Petitioner, however, attempts to distinguish *Ahlborn*. His efforts are not persuasive. Petitioner implies that *Ahlborn* should be cabined as a result of that decision coming before this Court on stipulated facts. Throughout the opinion, however, this Court made clear that it is irrelevant whether the applicable facts were reached by stipulation or by a judge or jury. Additionally, Petitioner relies on a statement in footnote 18 of the *Ahlborn* decision that the decision leaves open the issue of whether States may adopt procedures to prohibit settlement manipulation. 547 U.S. at 288 n.18. Like *Ahlborn*, that issue is not properly raised under the facts of this case. Here, the settlement agreement contained no allocation of damages. Therefore, the issue of what steps a State may take to prevent settlement manipulation is not presented. More importantly, to the extent that the Court were to address this issue, such procedures should not include arbitrary and

irrebuttable presumptions that would allow States to circumvent this Court's decision in *Ahlborn*.

The reimbursement to the state Medicaid program mandated by N.C. Gen. Stat. § 108A-57 frequently results in the state Medicaid program taking "more than the portion of [the] settlement that represents medical expenses." *Ahlborn*, 547 U.S. at 280. That is the case here. The Fourth Circuit correctly held that the North Carolina statute conflicts with the Medicaid Act and is therefore preempted.

ARGUMENT

The purpose of the Medicaid Act is to provide medical assistance to needy families whose income and resources are not sufficient to meet these costs. 42 U.S.C. § 1396 *et seq.* Congress' objective was to help such families in their time of need – not to cripple them with debts and liens for seeking such assistance. *See* 42 U.S.C. § 1396p.

In contrast, N.C. Gen. Stat. § 108A-57 provides that whenever a Medicaid beneficiary obtains an award or settlement in a claim against a third-party tortfeasor, North Carolina will either be paid in full or take one-third of any tort settlement – regardless of whether one-third fairly represents the portion of the settlement that is attributable to medical expenses. The North Carolina statute is inconsistent with Medicaid's anti-lien provision, 42 U.S.C. § 1396p, and this Court's decision in *Arkansas Department of Health & Human Services*

v. Ahlborn, 547 U.S. 268, 280-81 (2006). The Fourth Circuit correctly held that N.C. Gen. Stat. § 108A-57 is unenforceable and preempted by federal law.

I. NORTH CAROLINA'S STATUTE VIOLATES MEDICAID'S ANTI-LIEN PROVISION AND IS INCONSISTENT WITH THIS COURT'S DECISION IN *AHLBORN*.

As a condition of eligibility for medical assistance, an applicant for Medicaid services must assign certain rights to the state Medicaid program. 42 U.S.C. § 1396k. That assignment provision, however, is narrow. With respect to tort claims against third parties, the statute expressly limits the assignment to the right to recover for "payment of *medical care* from any third party." 42 U.S.C. § 1396k(a)(1)(A) (emphasis added); *accord* 42 U.S.C. § 1396a(a)(25)(H) (State's right of recovery against third parties is limited to payments made by the Medicaid program for "medical assistance"). The assignment does not extend to the beneficiary's right to recover lost wages, pain and suffering, disfigurement or similar damages from a tortfeasor. *Ahlborn*, 547 U.S. at 281. Additionally, Medicaid's anti-lien provision precludes a state Medicaid program from imposing a lien on the property of a Medicaid beneficiary on account of medical assistance paid or to be paid by the state Medicaid program.[4] 42 U.S.C. § 1396p(a)(1).

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[4] Medicaid's anti-lien statute does permit a lien following the death of the Medicaid beneficiary. It also provides for two

In *Ahlborn*, this Court considered an Arkansas statute that allowed Arkansas to impose a lien on a Medicaid beneficiary's tort settlement for an amount in excess of the portion of the settlement that represented payment for medical care. Rejecting the construction of the Medicaid Act advocated by Arkansas and by the United States as *amicus*, the Court held that Arkansas could not "lay claim to more than the portion of Ahlborn's settlement that represents medical expenses." 547 U.S. at 280. In *Ahlborn*, Arkansas was seeking to impose a lien on 39% of Heidi Ahlborn's tort settlement. Here, North Carolina is seeking to impose a lien on 33.3% of E.M.A.'s tort settlement. In both cases, the percentage is in excess of the portion of the settlement that represents payment for medical care. North Carolina's statute, just like the Arkansas statute struck down in *Ahlborn*, is inconsistent with the Medicaid anti-lien provision and is therefore unenforceable.

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exceptions to the anti-lien rule: (1) when a court has entered a judgment finding that benefits have been incorrectly paid to a beneficiary or (2) when a beneficiary who owns real property is receiving inpatient services at a medical facility and certain specific requirements are met. 42 U.S.C. § 1396p(a)(1). Neither of these two exceptions to the anti-lien provision is applicable here.

In *Ahlborn*, the parties assumed that a lien that was limited to medical expenses paid by the state Medicaid program would not be barred by the anti-lien provision. This Court therefore assumed, without deciding, that such a lien was not precluded by the plain language of 42 U.S.C. § 1396p(a)(1). *See* 547 U.S. at 284. That issue, however, was not ruled on by the Fourth Circuit and is not presented here. *See* Br. in Opp. at 16; Pet. App. 19a n.4.

The holding of *Ahlborn* is clear. The right of a state Medicaid program to seek reimbursement from a Medicaid beneficiary's settlement with a tortfeasor "extend[s] only to recovery of payments for medical care." *Id.* at 282; *accord id.* (any recovery by the state Medicaid program is limited to "that portion of a settlement that represents payments for medical care"). A state Medicaid program may not lay claim to payments from a third party that compensate the Medicaid beneficiary for lost wages, pain and suffering, and similar damages. *Id.* at 281. Allowing state Medicaid programs to share in a tort recovery that is properly allocated as payment for pain and suffering and lost wages – injuries for which the State has provided no compensation – would be "'absurd and fundamentally unjust.'" *Id.* at 288 n.19 (quoting *Flanigan v. Dep't of Labor & Indus.*, 869 P.2d 14, 17 (Wash. 1994)).[5]

The North Carolina statute, N.C. Gen. Stat. § 108A-57, is just as problematic as the statute at

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[5] Petitioner incorrectly, and without citation, asserts that a Medicaid recipient "has no right to reduce her reimbursement obligation because the recovery was less than the full amount of her damages." Pet. Br. at 30. *Ahlborn* holds to the contrary: "Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47 [the amount of the medical expenses paid by ADHS proportionally reduced as a result of Ahlborn being able to recover only one-sixth of her total damages], and the federal anti-lien provision affirmatively prohibits it from doing so." 547 U.S. at 292.

issue in *Ahlborn*.[6] The facts of the present case illustrate how the irrebuttable presumption created by N.C. Gen. Stat. § 108A-57 results in the state Medicaid program taking "more than the portion of [the] settlement that represents medical expenses." 547 U.S. at 280. As a result of her injuries, E.M.A. cannot crawl, walk, hold her head up or talk. J.A. 114. She is deaf and legally blind. *Id.* She has a severe brain injury which left her mentally retarded and with severe deficits in all activities of daily living. *Id.* She is unable to use her mouth to eat and therefore must be fed through a feeding tube. *Id.* Because she cannot clear her throat, E.M.A. requires frequent suctioning so that she does not gag on her own saliva. *Id.* Moreover, she has no control of her bowel or bladder function. *Id.* at 115.

The $1.9 million that NC DHHS paid toward E.M.A.'s medical expenses pales in comparison to the long list of other damages for which E.M.A.'s

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[6] Petitioner's brief refers in passing to another North Carolina statute, N.C. Gen. Stat. § 108A-59. *See* Pet. Br. at 6, 11. Whereas N.C. Gen. Stat. § 108A-57 speaks in terms of the State's right of subrogation with respect to "rights of recovery" that the Medicaid beneficiary may have against others, N.C. Gen. Stat. § 108A-59 speaks in terms of the State's assignment to "benefits" the Medicaid beneficiary is entitled to receive from third parties. The North Carolina Attorney General has opined that this difference in language is significant and that N.C. Gen. Stat. § 108A-59 applies only when the Medicaid beneficiary has a right to "benefits," such as a right to payments under a policy of insurance. Opinion of the North Carolina Attorney General, 1982 N.C. AG LEXIS 19 (Dec. 7, 1982); *but see Andrews v. Haygood*, 669 S.E.2d 310, 313 (N.C. 2008) (indicating that § 108A-57 implements § 108A-59), *cert. denied*, 557 U.S. 904 (2009).

settlement is intended to compensate her. E.M.A. faces a lifetime of pain and suffering, loss of enjoyment of life and complete dependence on her parents and others for all aspects of her care. Her injuries rendered her unable to work, taking from her a lifetime of wages. In addition, her economic damages go far beyond medical needs – and include architectural renovations, modified transportation and similar costs. In light of all of these damages which were compromised by the settlement, it is not reasonable for Petitioner to assume that of the $2.8 million settlement, the sum of $933,333.33 was being paid for past medical expenses and the remaining sum of $1,866,666.67 was intended to suffice as payment for the entirety of E.M.A.'s non-medical damages, as well as legal fees and costs.[7] At a minimum, E.M.A. should have the opportunity to obtain a fair allocation between medical and non-medical damages as the Fourth Circuit's remand contemplates.

Despite E.M.A.'s substantial damages, only limited resources were available to compensate E.M.A. for her injuries. As a result of a long history of drug abuse and addiction, E.M.A.'s treating physician (the principal defendant in her tort claim) surrendered his medical license in May 2000 (three months after delivering E.M.A.). *See Armstrong v.*

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[7] Under N.C. Gen. Stat. § 108A-57, the State is not responsible for attorneys' fees and court costs. Moreover, the amount of the State's lien is not adjusted to account for those fees and costs. Rather, the State is guaranteed that it will recover one-third of any settlement or judgment, regardless of the cost of achieving that award.

Barnes, 614 S.E.2d 371, 374 (N.C. Ct. App.), *discr. review denied*, 621 S.E.2d 173 (N.C. 2005). Due to the risks and costs of pursuing the collection of a judgment against an individual, E.M.A. and her parents settled the malpractice claim for $2.8 million – a small fraction of E.M.A.'s overall damages.[8]

Here, Petitioner is seeking to recover a sum ($933,333.33) that is far in excess of the portion of the settlement that reflects payment for medical expenses. E.M.A. was forced to give up a substantial portion of her recovery simply because her treating physician was not sufficiently solvent to pay her claim in full. The State should not be immune from sharing in that loss proportionally. E.M.A. has already borne a substantial reduction in her recovery as a result of the lack of available insurance. Petitioner now seeks to compound that loss by requiring E.M.A. to take a portion of her settlement that would be fairly allocable to damages other than medical expenses and remit that payment to the State in order to ensure that the State gets one-third of the settlement. Such a result is "'fundamentally unjust.'" *Ahlborn*, 547 U.S. at 288 n.19 (quoting

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[8] Despite the horrific nature of E.M.A.'s injuries (which are undisputed), Petitioner asserts that all damages other than medical expenses are subject to "speculation," "manipulat[ion]," and "exaggerat[ion]." Pet. Br at 31-32. Moreover, Petitioner seeks to diminish the magnitude of E.M.A.'s injuries by asserting that she will be tempted to "inflate her claim for non-medical damages." Pet. Br. at 32. The evidentiary hearing ordered by the Fourth Circuit would simply provide E.M.A. with the opportunity to demonstrate that there is no exaggeration of her damages.

Flanigan v. Dep't of Labor & Indus., 869 P.2d 14, 17 (Wash. 1994)).

1. Petitioner's efforts to distinguish *Ahlborn* should be rejected.

Like the North Carolina Supreme Court in *Andrews v. Haygood*, 669 S.E.2d 310, 313 (N.C. 2008), *cert. denied*, 557 U.S. 904 (2009), Petitioner implies that this Court's decision in *Ahlborn* should be read narrowly, given that Ms. Ahlborn and Arkansas stipulated to the plaintiff's total damages. *See* Pet. Br. at 17 ("*Ahlborn* was limited to the narrow issue [framed by Arkansas' stipulation.]"); *id.* ("Because of the controlling stipulations, the Court had no reason to address any particular method for determining how much of a settlement, in the absence of a stipulation, represents payment for medical expenses."); *Andrews*, 669 S.E.2d at 313 (*Ahlborn* controls only "when there has been a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement"). This Court's opinion in *Ahlborn* is not so limited.

Throughout the *Ahlborn* decision, this Court recognized that the stipulation that was reached by the parties had the same effect as if a judge or jury had made factual findings with respect to an allocation. As this Court stated, "[g]iven the stipulation between ADHS and Ahlborn, there is no textual basis for treating the settlement here differently from a judge-allocated settlement or even a jury award * * * *" 547 U.S. at 282 n.12. The Court further noted that the effect of the stipulation "is the same as if a trial judge had found that

Ahlborn's damages amounted to $3,040,708.12[, but] she could only recover one-sixth of those damages." *Id.* at 281 n.10.

In *Ahlborn,* this Court unanimously held that any lien asserted by a state Medicaid program against a tort settlement is limited to the portion of the settlement that represents payment for medical expenses. The fact that the record in *Ahlborn* was based on stipulations – rather than an allocation reached by a judge or jury – is irrelevant. To the extent that Petitioner suggests that the *Ahlborn* decision is somehow limited because of the "controlling stipulations" reached in that case, Pet. Br. at 17, that suggestion is without merit.

2. Petitioner's reliance on the traditional authority of States to regulate tort claims is misplaced.

Petitioner asserts that States have historically been afforded broad authority to regulate tort claims.[9] Pet. Br. at 20-23. Petitioner is correct that state tort law generally lies within the domain of the state legislature. *See Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984) (recognizing "the States'

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[9] In his brief, Petitioner cites, as an example, N.C. Gen. Stat. § 90-21.19, which caps non-economic damages in medical malpractice cases in North Carolina at $500,000. Pet. Br. at 22. Petitioner, however, fails to inform this Court that this statute was enacted in 2011 and has no applicability to E.M.A.'s medical malpractice claim, which was filed in 2003. *See* Act of June 13, 2011, ch. 400, § 7, 2011 N.C. Sess. Laws 1712, 1715.

traditional authority to provide tort remedies to their citizens"). That undisputed principle, however, simply does not advance the State's argument.

The issue before the Court does not concern the province of States with respect to tort law. Rather, the issue before the Court is one of property rights: Did Congress intend to preclude States from placing liens on the property of Medicaid beneficiaries? *See Ahlborn*, 547 U.S. at 286. The lien created by N.C. Gen. Stat. § 108A-57 impacts E.M.A.'s property interest (i.e., the proceeds of a chose in action that has been settled). Moreover, the lien is not limited to settlements of claims that are based on North Carolina tort law. If, for example, a Medicaid beneficiary were to bring a cause of action against a third-party tortfeasor based exclusively on a federal statutory right (such as the Federal Employers' Liability Act, 45 U.S.C. § 51), NC DHHS would assert a lien on that award or settlement to the same extent as if the action had been based on North Carolina's common law of negligence.

The present appeal does not involve substantive state tort law. Even if state tort laws were relevant here, those tort laws would still have to be consistent with federal law. *See, e.g., Riegel v. Medtronic, Inc.*, 552 U.S. 312 (2008); *Geier v. Am. Honda Motor Co.*, 529 U.S. 861 (2000); *see also* 42 U.S.C. § 9658 (extending state statute of limitations for personal injury and property damage claims arising from exposure to hazardous substances).

The real issue raised by this appeal is whether Congress has precluded state Medicaid programs

from seizing settlement proceeds that are in excess of the portion of the settlement that represents payment for medical care. As *Ahlborn* instructs and as set out above, States cannot. A discussion of the traditional authority of States to create (and restrict) tort remedies adds nothing to the analysis.[10]

3. North Carolina's statute does not constitute a fair and appropriate allocation of damages between medical expenses and other damages.

Picking and choosing phrases from throughout the *Ahlborn* decision, Petitioner argues that the North Carolina statute serves as a fair allocation between medical expenses and other damages. *Compare* Pet. Br. at 23 ("North Carolina's statutes apportion, in advance of a settlement or judgment, the medical services portion of any recovery of damages."), *with Ahlborn*, 547 U.S. at 288 ("[T]he risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for

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[10] Equally perplexing is Petitioner's reliance on N.C. Gen. Stat. §§ 44-49 and 44-50. These two statutes restrict the amount of the lien that is afforded to health care providers when: (1) the provider has not been paid in full, (2) the patient has obtained a personal injury award, and (3) the award includes payment for those medical expenses. The statute in no way precludes the health care provider from pursuing the patient's indebtedness by means other than the lien – such as suing the patient for non-payment. In contrast, the federal Medicaid program precludes health care providers from bringing a claim against Medicaid beneficiaries for any unpaid medical expenses. *See* 42 C.F.R. § 447.15.

decision."); *see also* Pet. Br. at 20 (arguing that the North Carolina statute "provides a fair, certain and effective solution").[11] The North Carolina statute, however, is not an allocation formula at all. Rather, it is merely an effort, as Petitioner readily admits, to ensure that there is some incentive for plaintiffs' attorneys to bring these claims, which inure to the benefit of the state Medicaid program. Pet. Br. at 25 (North Carolina statute shields a portion of the tort settlement from the Medicaid lien "[a]s an incentive for the recipient to pursue the action"). More importantly, the statute does not approach any semblance of a fair allocation between medical expenses and other damages.

The one-third cap on North Carolina's Medicaid lien precedes the *Ahlborn* decision by a decade. *See* Act of Aug. 3, 1996, ch. 18, § 24.2, 1995 N.C. Sess. Laws (2d Extra Sess. 1996) 525, 774-75. Accordingly, N.C. Gen. Stat. § 108A-57 cannot be viewed as an effort to conform North Carolina's lien to this Court's directive in *Ahlborn*. This is further confirmed by the decisions of the North Carolina appellate courts construing this statute pre- and post-*Ahlborn*.

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[11] Petitioner's effort to describe the North Carolina statute as an "advance agreement" is misplaced. The *Ahlborn* opinion notes that the allocation issue can be resolved by an agreement between the Medicaid beneficiary and the state Medicaid program. 547 U.S. at 288. N.C. Gen. Stat. § 108A-57 is a unilateral dictate by the State as to the amount of the State's lien. The statute cannot be characterized as an "advance agreement" between the Medicaid beneficiary and the state Medicaid program.

Prior to this Court's decision in *Ahlborn*, the North Carolina appellate courts repeatedly held that the purpose of N.C. Gen. Stat. § 108A-57 is to ensure that the State receives full reimbursement (subject only to the one-third cap) from any tort settlement or award obtained by a Medicaid beneficiary. *Ezell v. Grace Hosp., Inc.*, 631 S.E.2d 131 (N.C. 2006) (reversing for the reasons set out in the dissent); *Ezell v. Grace Hosp., Inc.*, 623 S.E.2d 79, 84 (N.C. Ct. App. 2005) (Steelman, J., dissenting in part), *rev'd*, 631 S.E.2d 131 (N.C. 2006); *Campbell v. N.C. Dep't of Human Res.*, 569 S.E.2d 670, 671 (N.C. Ct. App. 2002). Accordingly, the North Carolina courts emphasized that under the statute, it is "irrelevant whether a settlement compensated a plaintiff for medical expenses." *Ezell*, 623 S.E.2d at 84 (Steelman, J., dissenting in part). Rather, the State's "broad right of subrogation" under N.C. Gen. Stat. § 108A-57 entitles it "to recover the full amount of its lien," subject only to the one-third cap. 623 S.E.2d at 84-85. Thus, prior to *Ahlborn*, the North Carolina Supreme Court recognized that N.C. Gen. Stat. § 108A-57 was never intended to serve as a reasonable allocation between medical expenses and other damages. After *Ahlborn*, however, the North Carolina Supreme Court now refers to the statute as "a reasonable framework" that comports with *Ahlborn*. *Andrews v. Haygood*, 669 S.E.2d 310, 314 (N.C. 2008), *cert. denied*, 557 U.S. 904 (2009).

Petitioner claims that the North Carolina statute merely defines the portion of a damage award which "represent[s] compensation for past medical expenses." Pet. Br. at 17. Before the Fourth Circuit,

Petitioner all but admitted that the one-third cap was fashioned from whole cloth and had no foundation in any empirical evidence. Pet. App. 20a ("With commendable candor, the Secretary concedes that the statutory presumption that the state's recovery of one-third of an unallocated lump-sum tort settlement is fair and appropriate rests on nothing more than the state's notion of how attorneys and insurance adjusters typically value tort cases.") (internal quotations omitted). Moreover, as the Fourth Circuit recognized, in the absence of a mechanism for Medicaid beneficiaries to challenge the State's presumption, there would be nothing to "prevent states from allocating 75%, 90% or even 100% of a settlement to medical expenses, thereby eviscerating the rule promulgated by *Ahlborn*." Pet. App. 53a. Under Petitioner's argument, the outcome of the *Ahlborn* case would have been completely different if Arkansas had simply adopted a statute that created an irrebuttable presumption that medical expenses constitute 39% of any tort award or settlement.[12] Such a statute, in Petitioner's view, would have overridden the fact that in *Ahlborn*, medical expenses were only one-sixth of the total damages that Ms. Ahlborn sustained. 547 U.S. at 274.

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[12] In *Ahlborn*, the Medicaid beneficiary obtained a settlement in the amount of $550,000. 547 U.S. at 274. Medical expenses paid by Arkansas' Medicaid program totaled $215,645. *Id.* Thus, had Arkansas adopted an irrebuttable presumption of 39% (215,645 ÷ 550,000), it would not have been required, under Petitioner's theory, to make any reduction to its asserted lien.

The arbitrary nature of Petitioner's "one-third formula" is highlighted by the fact that the statute effectively recognizes that the ratio between medical expenses and other damages varies from case-to-case. The statute is not an estimate that for every dollar of medical expenses incurred by a tort victim, the plaintiff can reasonably be expected to recover total damages that are three times the amount of those medical expenditures. Instead, the statute recognizes that the amount of medical expenses will frequently be less than one-third of the plaintiff's total damages. N.C. Gen. Stat. § 108A-57 ("the amount paid to the Department *shall not exceed one-third* of the gross amount obtained or recovered") (emphasis added). As such, the statute cannot be viewed, as Petitioner claims, as an "allocation formula." Pet. Br. at 23. Rather, it is merely a statement by the North Carolina General Assembly that even though the relationship between medical expenses and other damages varies for each case, North Carolina will insist that it will either be paid in full or take one-third of any tort settlement – regardless of whether one-third fairly represents the portion of the settlement that is attributable to medical expenses.

The unfairness of the State's purported "allocation formula" can be seen through a hypothetical. Suppose a young, professional photographer is injured in a boating accident. Debris from the accident strikes the photographer in the face and causes him to lose both eyes, but he otherwise sustains relatively little bodily injury. Unable to pursue his profession as a photographer, the victim conservatively incurs damages of

approximately $650,000 for lost wages alone (based on a work-life expectancy of 32 years, a loss of $35,000 per year in annual income and reduction to present value). Being without financial resources, the victim is forced to turn to Medicaid for assistance, and the Medicaid program pays $10,000 in medical bills. The driver of the boat dies shortly after the accident with few assets in his estate. All of the estate's assets ($30,000) are used to pay the photographer's claim. Under the North Carolina statute, the $30,000 would be divided as follows: $10,000 to the state Medicaid program and $20,000 to the victim of the accident. Under these circumstances, the tort victim would receive roughly 3% of his "hard" economic damages, while the State would receive 100% of the medical payments it made.

One further example illustrates that the North Carolina statute does not truly stand as an allocation between medical expenses and other damages. Suppose E.M.A. had gone to trial against her treating physician and obtained a jury verdict of $42 million, but was able to collect only the sum of $2.8 million through diligent collection efforts. Faced with such a fact pattern, the state Medicaid program would insist on receiving $933,333.33 from the $2.8 million that was collected from the defendant. The statute provides: "[T]o the extent of payments under this [provision,] the State * * * shall be subrogated to all rights of recovery * * * *" N.C. Gen. Stat. § 108A-57(a). The statute continues: "[T]he amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered." *Id.* Under the plain wording of the

statute, as each payment is received, the beneficiary's attorney must take one-third of that payment and transmit it to the state Medicaid program. Thus, NC DHHS would insist on payment of $933,333.33 regardless of whether (1) E.M.A. had settled for $2.8 million or (2) E.M.A. had obtained a jury verdict of $42 million but could collect only $2.8 million.

The North Carolina statute creates an irrebuttable presumption that is not grounded in reality. North Carolina's statutory scheme forces Medicaid beneficiaries to take settlement proceeds that properly are allocable to non-medical expense damages and use those funds to reimburse the State for medical expenses. Such an approach violates both the Medicaid Act and this Court's decision in *Ahlborn*.

4. Petitioner's attacks on the hearing ordered by the Fourth Circuit are unfounded.

Petitioner argues that North Carolina's statutory scheme promotes efficiency. Pet. Br. at 26. Petitioner further asserts that conducting an evidentiary hearing would be "wasteful, time consuming, and costly." Pet. Br. at 28. Petitioner fails to recognize, however, that these very arguments were presented in *Ahlborn* and rejected by this Court. *See, e.g.*, Br. for U.S. as *Amicus Curiae, Arkansas Dep't of Health & Human Servs. v. Ahlborn,* No. 04-1506, at 17 n.7 (pointing out perceived difficulties with post-settlement hearings); Br. for State of Washington *et al.* as *Amici Curiae, Arkansas Dep't of Health & Human Servs. v.*

Ahlborn, No. 04-1506, at 8-10 (noting costs to States of post-settlement allocation hearings). In *Ahlborn*, this Court expressly stated that if the Medicaid beneficiary and the state Medicaid program are unable to reach an agreement with respect to the allocation of damages, the allocation can and should be resolved "by submitting the matter to a court for decision."[13] 547 U.S. at 288.

Unquestionably, it would be far more cost efficient for the State to simply adopt an arbitrary and irrational formula for the allocation of damages, rather than being troubled with having to negotiate with Medicaid beneficiaries to reach a fair and appropriate allocation of damages. When, however, a State's approach to allocation (as here) results in the state Medicaid program seizing a portion of the settlement that is not payment for medical expenses, *Ahlborn* holds that the state statute violates Medicaid's anti-lien provision and is unenforceable.

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[13] Petitioner's brief devotes numerous pages to an explanation as to why a Medicaid beneficiary should not be able to structure a settlement in such a way as to allocate various categories of damages to the detriment of the state Medicaid program. Pet. Br. at 30-33. The Fourth Circuit's decision does not authorize Medicaid beneficiaries to do so. If the Medicaid beneficiary and the state Medicaid program are unable to reach an agreement with respect to allocation, the dispute should be resolved by a judicial hearing. At that hearing, the state Medicaid program would not be bound by a settlement agreement in which it was not a party. Only the National Governors Association *et al.* – *amici* supporting *Petitioner* – argue that state Medicaid programs are bound by the allocation that a Medicaid beneficiary and tortfeasor reach in their settlement agreement. Br. of NGA *et al.* as *Amici Curiae*, at 10-11.

Petitioner complains that there is no "realistic basis" for appropriately allocating damages in a post-settlement hearing. Pet. Br. at 28. That argument also fails. At a post-settlement hearing, the Medicaid beneficiary and the state Medicaid program present evidence as to the amount of the total damages, the amount of the medical expenses, and any case-specific factors that would cause either or both of these categories to be settled for less than full value. As noted by this Court in *Ahlborn*, similar allocation hearings have been conducted by courts in a variety of contexts. *See* 547 U.S. at 288 n.18. Moreover, numerous States have successfully implemented statutes that, consistent with *Ahlborn*, provide for allocation hearings if the Medicaid beneficiary and the state Medicaid program are unable to agree on an appropriate allocation. *See, e.g.*, Cal. Welf. & Inst. Code § 14124.76; Haw. Rev. Stat. § 346-37(h); Mo. Rev. Stat. § 208.215; 62 Pa. Stat. Ann. § 1409.1.

As this Court recognized in *Ahlborn*, when the Medicaid beneficiary and the state Medicaid program are unable to agree on an allocation, the dispute can readily be resolved by a post-settlement hearing. Petitioner has failed to come forward with any plausible argument as to why this aspect of the *Ahlborn* decision should be revised by this Court. The decision of the Fourth Circuit to remand the action to the district court for an appropriate allocation determination is consistent with *Ahlborn* and the Medicaid Act.

II. ALTHOUGH *AHLBORN* LEAVES OPEN WHETHER STATES MAY ADOPT PROCEDURES TO PROHIBIT SETTLEMENT MANIPULATION, THAT POSSIBILITY DOES NOT SAVE THE NORTH CAROLINA STATUTE.

Petitioner relies heavily on footnote 18 of this Court's decision in *Ahlborn*. Pet. Br. at 19, 23-24. There, the Court noted, "As one *amicus* observes, some States have adopted special rules and procedures for allocating tort settlements in circumstances where, for example, private insurers' rights to recovery are at issue." 547 U.S. at 288 n.18 (citing Br. for Association of Trial Lawyers of America ("ATLA") as *Amicus Curiae, Arkansas Dep't of Health & Human Servs. v. Ahlborn*, No. 04-1506, at 20-21). The Court continued: "[W]e leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation." 547 U.S. at 288 n.18. This footnote does not lend support to Petitioner's argument.

The *amicus* brief cited in this footnote explained that it is not unusual for courts to conduct post-settlement allocation hearings. ATLA Br. at 20. The *amicus* noted that courts must frequently conduct such post-settlement hearings to allocate settlements between taxable and non-taxable income categories and to resolve subrogation claims by private insurers. *Id.* at 20-21. Thus, it would appear that the Court's reference to "rules and procedures" in footnote 18 of the *Ahlborn* decision was intended to encompass procedures with respect to post-settlement hearings or similar devices that

would result in a fair allocation of settlement proceeds – not rules and procedures that would permit a State, through the use of an irrebuttable presumption, to achieve virtually the same result as the statute that was struck down in *Ahlborn*.

More importantly, Petitioner has come forward with no evidence that the risk of settlement manipulation is so pervasive as to justify special procedures "to meet concerns about settlement manipulation." *Ahlborn*, 547 U.S. at 288 n.18. Nor do the facts of this case raise even the hint of settlement manipulation. NC DHHS was promptly notified of the tort claim and the proposed settlement of that claim. *See* 4th Cir. J.A. 185-87. NC DHHS, however, did not respond to those notices and did not seek to intervene (or participate in the prosecution of this tort claim) until after the settlement had been approved by the state trial court. Petitioner's concern for the risk of settlement manipulation is largely irrelevant here, given that there was no allocation in the settlement. Moreover, even if E.M.A. and the tortfeasors had drafted the settlement agreement in such a way as to allocate away the interests of the state Medicaid program, that document would not be binding on the State.

A number of States have successfully implemented post-settlement hearings in accordance with the *Ahlborn* decision. Pet. App. 47a-48a. Petitioner fails to cite to any practical difficulties that these States have incurred in doing so. This Court need not address the issue left open in *Ahlborn* by footnote 18. 547 U.S. at 288 n.18. Moreover, even if this case were an appropriate

vehicle for addressing settlement manipulation (which it is not), the response should not be to permit States to implement an irrebuttable presumption that deprives Medicaid recipients of settlement proceeds that are intended to provide compensation for non-medical expense damages.

III. PETITIONER'S SUGGESTION THAT THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS APPROVED THE NORTH CAROLINA STATUTE AND THAT SUCH DECISION SHOULD BE GIVEN DEFERENCE IS MISPLACED.

In his brief, Petitioner asserts that the United States Department of Health and Human Services has approved the North Carolina statute and that such approval should be given deference by this Court. Petitioner's argument, however, fails for two reasons. First, Petitioner has not cited to any statement or official position of the United States Department of Health and Human Services ("HHS") that would be entitled to deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Second, the informal letter that Petitioner requests be afforded deference is flatly inconsistent with the text of the Medicaid anti-lien provision. Accordingly, deference would not be appropriate.

1. Petitioner asserts that the Centers for Medicare and Medicaid Services ("CMS") "specifically declared that North Carolina's statute

comports with the anti-lien provision as it was construed in *Ahlborn*." Pet. Br. at 34. In support of this statement, Petitioner cites to a letter written by an Acting Associate Regional Administrator of the Division of Medicaid & Children's Health Operations (Mary Justis) in December 2009. Pet. App. 141a-42a. This letter appears to be in response to an inquiry by a North Carolina Congressman on behalf of a constituent – the plaintiff in *Andrews v. Haygood*, 669 S.E.2d 310 (N.C. 2008), *cert. denied*, 557 U.S. 904 (2009). Petitioner, however, fails to attach the Congressman's letter or to provide any information with respect to Ms. Justis' role or level of authority within HHS.

Ms. Justis' letter is nothing more than an effort by an HHS employee to appease the concerns of a Congressman who had been contacted by one of his constituents. The letter, on its face, does not rise to the level of a formal opinion letter by HHS. As this Court has repeatedly noted, "opinion letters – like interpretations contained in policy statements, agency manuals, and enforcement guidelines, all of which lack the force of law – do not warrant *Chevron*-style deference." *Christensen v. Harris Cnty.*, 529 U.S. 576, 587 (2000); *accord United States v. Mead Corp.*, 533 U.S. 218, 231-32 (2001) (letter ruling by U.S. Customs Service not entitled to *Chevron* deference). Petitioner does not and cannot assert that Ms. Justis' letter carries the force of law. The letter is not entitled to *Chevron* deference.

Moreover, the letter carries little to no persuasive force. In the letter, Ms. Justis concludes that NC DHHS does not appear to have disregarded

directives from CMS. Her conclusion is based largely on her understanding that the United States Supreme Court "affirmed" the North Carolina Supreme Court's decision in *Andrews* by denying certiorari. Pet. App. 141a. Ms. Justis' erroneous legal conclusion as to the effect of this Court's denial of certiorari should be afforded no deference.

2. Deference to an agency's construction of a federal statute should occur only when "Congress has explicitly left a gap for the agency to fill." *Chevron,* 467 U.S. at 843-44; *see id.* at 842 (If Congressional intent is clear, "that is the end of the matter."). Here, Congressional intent is clear, and there is no gap for the agency to fill.

Medicaid's anti-lien provision unambiguously precludes state Medicaid programs from placing liens on a Medicaid beneficiary's tort settlement for an amount in excess of the portion of the settlement that represents payment for medical care. Any statement by the agency to the contrary is entitled to no deference. *See Ahlborn,* 547 U.S. at 289-92.

Prior to *Ahlborn*, HHS took the position that the Medicaid program has a right superior to that of Medicaid beneficiaries with respect to any third party tort settlement. HHS read the Medicaid Act as authorizing HHS to recoup 100 percent of the medical expenses paid on behalf of a beneficiary before the beneficiary could obtain any portion of the settlement proceeds. The Agency's position was detailed at length in two separate opinions by the HHS Appeals Board. *In re Wash. State Dep't of Social & Health Servs.*, Dec. No. 1561, 1996

HHSDAB LEXIS 717 (HHS Dep't App. Bd. Feb. 7, 1996): *In re Cal. Dep't of Health Servs.*, Dec. No. 1504. 1995 HHSDAB LEXIS 996 (HHS Dep't App. Bd. Jan. 5, 1995). The decisions of the Appeals Board read: "HCFA[14] * * * characterize[s] recoveries from third parties first as payments for medical care." *In re Wash. State Dep't of Social & Health Servs.*, 1996 HHSDAB LEXIS at *13; *In re Cal. Dep't of Health Servs.*, 1995 HHSDAB LEXIS at *20. The opinions further note the Agency's position that: "Medicaid has superior status to the recipient in relation to the tortfeasor to recover costs Medicaid incurred on behalf of the recipient * * * *" *In re Wash. State Dep't of Social & Health Servs.*, 1996 HHSDAB LEXIS at *13; *In re Cal. Dep't of Health Servs.*, 1995 HHSDAB LEXIS at *20.

This Court, in *Ahlborn*, rejected the argument that the Agency's long-standing view of Medicaid's anti-lien statute was entitled to deference. The Court noted that the two opinions of the Appeals Board "rest on a questionable construction of the federal third-party liability provisions." 547 U.S. at 289. Recognizing that the adjudications by HHS "typically warrant deference," the Court concluded that the Agency's construction of Medicaid's anti-lien

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[14] The Health Care Financing Administration ("HCFA") was renamed the Centers for Medicare and Medicaid Services ("CMS") in 2001. *See* Centers for Medicare & Medicaid Services; Statement of Organization, Functions and Delegations of Authority, Reorganization Order, 66 Fed. Reg. 35,437 (July 5, 2001).

provision was entitled to no deference because of the Agency's "conscious disregard for the statutory text." *Id.* at 292.

Just as the two opinions of the HHS Appeals Board disregard Congress' expressed intent, Ms. Justis would allow North Carolina to seize the portion of a tort settlement that does not represent payment for medical expenses. In that the opinions set out in Ms. Justis' letter are contrary to the statutory text, her letter should be afforded no deference.[15]

IV. CONTRARY TO THE SUGGESTION OF PETITIONER'S *AMICI*, STATES ARE NOT FREE TO IGNORE MEDICAID'S ANTI-LIEN PROVISION.

In its *amicus* brief, the State of Texas (joined by ten other States) makes two arguments not ruled on or considered by any of the courts below. First,

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[15] In addition to Ms. Justis' letter, Petitioner also asserts that a July 3, 2006, CMS memo should be given deference. Pet. Br. at 34-45; *see* Pet. App. 124a-38a. That memo, however, cannot be read as expressing approval or support of N.C. Gen. Stat. § 108A-57. In fact, the memo does not even cite the North Carolina statute. Rather, the memo emphasizes that a "State may only recover from the amount of a third party payment to a Medicaid recipient that is allocated to healthcare (medical) items and services." Pet. App. 129a. The memo should not be read as HHS' approval of state Medicaid lien statutes that create irrebuttable presumptions with respect to the allocation between medical expenses and other damages.

Texas asserts that this Court's decision in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), precludes the federal district court from proceeding with a hearing on the appropriate allocation between medical expenses and other damages. Second, Texas asserts that state laws cannot be preempted by Medicaid's anti-lien provision. Petitioner does not press either of these theories before this Court. *See, e.g.*, Pet. Br. at 3 n.1. Both of Texas' arguments lack merit.

1. The Fourth Circuit's decision is consistent with *Pennhurst*.

Citing *Pennhurst*, Texas asserts that any conditions placed on the States by the Medicaid Act must be set out unambiguously, and the States must accept these conditions voluntarily and knowingly. Texas Br. at 6 (citing *Pennhurst* and *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291 (2006)). Texas faults the Fourth Circuit for not citing to *Pennhurst* in its opinion, even though the *Pennhurst* decision was never cited or relied on by Petitioner in any of the briefing or arguments below. Texas Br. at 6. Contrary to Texas' argument, the Fourth Circuit's decision does not run afoul of *Pennhurst*.

As Texas recognizes, when federal spending legislation is unambiguous, the rule of *Pennhurst* is not implicated. *Id.* Here, Congress has laid down a clear and unambiguous directive that precludes States from seizing the property (such as tort settlements) of Medicaid beneficiaries. The language of Medicaid's anti-lien statute places States on notice

that they may not take such property: "No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan * * * *" 42 U.S.C. § 1396p(a)(1). In *Ahlborn*, this Court reiterated that the Medicaid Act unambiguously precludes States from seizing "more than * * * that portion of a judgment or settlement that represents payment for medical expenses." 547 U.S. at 278; *see also id.* at 289-92 (refusing to afford deference to HHS' construction of the Medicaid anti-lien provision in that the statutory text is unambiguous). Texas concedes that the Medicaid statute is unambiguous. Texas Br. at 8 (Medicaid Act "unambiguously preclude[s] a state Medicaid plan from imposing a lien against an individual's 'property,' except for damages that the beneficiary has recovered for medical expenses from a third-party tortfeasor"). Accordingly, the *Pennhurst* inquiry should end here.

Texas, however, argues that even though the provisions of the Medicaid Act are clear and unambiguous, the Act does not set out with precision how States must comply with the anti-lien provision. Texas Br. at 10. The answer is clear. Any state statute, rule or regulation that results in the portion of a tort recovery attributable to damages other than medical expenses being used to pay off the State's lien is invalid and unenforceable. Thus, state Medicaid programs are precluded from seizing settlement proceeds, unless the portion of the settlement that constitutes payment for medical expenses is readily ascertainable (such as by an agreement between the beneficiary and the Medicaid

program). Where the ownership interest in the settlement proceeds is in doubt, the property interests must be resolved by the courts (or through an appropriate administrative adjudication). This is precisely what our court system has done for hundreds of years. *See Wabash Ry. Co. v. Elliott*, 261 U.S. 457 (1923) (resolving lien against settlement proceeds); *Ry. Co. v. Stewart*, 95 U.S. 279, 283 (1877) (recognizing that courts are called on to "appropriat[e] * * * the fruits of * * * settlement[s]"); *see also Zivotofsky v. Clinton*, 132 S. Ct. 1421, 1440 (2012) (Breyer, J., dissenting) (noting that society traditionally turns to courts to protect property interests).

North Carolina's statutory scheme violates the unambiguous language of Medicaid's anti-lien provision. The Fourth Circuit's decision is consistent with *Pennhurst* and its progeny.

2. Medicaid's anti-lien provision preempts inconsistent state laws.

Texas brings forward a further argument that was not presented below and which is not raised by the Petitioner. Specifically, Texas argues that because the Medicaid Act was enacted pursuant to Congress' spending authority, the Act does not preempt state laws that are inconsistent with the provisions of the Act. In making this argument, Texas concedes that some spending legislation "impose[s] binding legal obligations on entities that accept federal funds." Texas Br. at 18. Thus, Texas appears to recognize that some spending legislation preempts conflicting state laws.

This Court has struck down a variety of state laws that conflict with the Social Security Act, including the Medicaid Act. *Ahlborn*, 547 U.S. at 292 (Arkansas' lien provisions are unenforceable as a result of 42 U.S.C. § 1396p); *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 478 (1996) (enjoining enforcement of provision of Arkansas State Constitution that conflicts with the Hyde Amendment); *Bennett v. Arkansas*, 485 U.S. 395, 397-98 (1988) (Arkansas statute allowing prison system to seize inmate's Social Security benefits conflicts with 42 U.S.C. § 407(a) and therefore violates the Supremacy Clause); *Blum v. Bacon*, 457 U.S. 132, 145-46 (1982) (New York statute that conflicts with Social Security Act's provisions relating to Emergency Assistance invalid under the Supremacy Clause); *Carleson v. Remillard*, 406 U.S. 598, 600 (1972) (California regulation in conflict with Social Security Act's requirements invalid under the Supremacy Clause); *Townsend v. Swank*, 404 U.S. 282, 283 (1971) (Illinois statute that conflicts with eligibility provisions of Social Security Act is invalid under the Supremacy Clause). Given that spending legislation preempts some conflicting state laws, the question then becomes which federal statutes impose binding legal obligations and which do not. That answer must be grounded on Congressional intent.

Here, there is little question that Congress intended to impose a binding obligation on States. The language that Congress chose is mandatory, not precatory: "No lien may be imposed * * * *" 42 U.S.C. § 1396p(a)(1); *see Blessing v. Freestone*, 520 U.S. 329, 341 (1997) (to give rise to a federal right,

statutory provision "must be couched in mandatory rather than precatory terms"). Congress clearly intended this provision to have teeth. The language of this provision further demonstrates Congress' intent to benefit individuals such as E.M.A. 42 U.S.C. § 1396p(a)(1) (referring to liens against "any individual"); *see also* 42 U.S.C. § 1396p(b)(1) ("an individual").

Under Texas' view of the Medicaid Act, States could freely seize assets of Medicaid beneficiaries in blatant disregard of federal law. *See* 42 U.S.C. § 1396p. Texas' argument would allow States to take not only settlement proceeds, but also the corpus of a Special Needs Trust, as well as the homes of Medicaid beneficiaries. *See* 42 U.S.C. § 1396p(a)(1)(B), (d)(4)(A); *see also* 42 U.S.C. § 1396p(b) (precluding States from seeking recoveries from Medicaid recipients). According to Texas, the only remedy available if States were to disregard these clear directives of the Medicaid Act would be to hope that the HHS Secretary would choose to reduce Medicaid reimbursements being made to that State. The threat that States may lose some Medicaid reimbursement funds would provide little comfort to the Medicaid beneficiary who is rendered homeless by a state statute that contravenes the Medicaid Act. Moreover, Medicaid beneficiaries would be completely without any means to rectify the violation of federal law when the HHS Secretary agrees with the State's actions. That, of course, was the case in *Ahlborn* where the Secretary was supporting Arkansas' argument that Arkansas had a superior right to the proceeds of Ms. Ahlborn's settlement.

Texas' novel theory would not simply harm Medicaid beneficiaries. It would effectively gut the enforceability of other provisions of the Medicaid Act. For example, 42 U.S.C. § 1396u-6 clearly authorizes the HHS Secretary to limit the liability of contractors employed to carry out investigations under the Medicaid Integrity Program. 42 U.S.C. § 1396u-6(a), (c)(4). Those contractors are not to be held civilly or criminally liable under state or federal law as a result of performing their duties under the Program. *See* 42 C.F.R. § 455.202(a). Under Texas' theory, a state statute imposing civil or criminal liability on contractors for actions taken to investigate Medicaid fraud would not be preempted by the Medicaid Act. That result cannot be squared with Congress' obvious intent to shield from liability the individuals investigating Medicaid's efficacy. As a further example from the Medicaid Act, Congress has authorized the HHS Secretary to issue subpoenas and to require testimony in matters under investigation. 42 U.S.C. § 1396q (incorporating provisions of 42 U.S.C. § 405). A state statute directing those subpoenas to be null and void would conflict with Congress' clear intent to require compliance with the Secretary's subpoenas. Congress intended for certain provisions of the Medicaid Act, such as 42 U.S.C. §§ 1396p, 1396q and 1396u-6, to preempt state laws in conflict with the Act.

Not only does Texas advocate a position that would wreak havoc on the day-to-day administration of the Medicaid Act, Texas also (implicitly) asks this Court to overrule *Ahlborn*. As set out above,

Ahlborn held that when a Medicaid beneficiary enters into a settlement with a third-party tortfeasor, the State may not assert a lien on that settlement in an amount that "exceeds the portion of the settlement that represents medical costs." 547 U.S. at 272. Any lien by a state Medicaid program that attempts to do so "contravene[s] federal law and [is] therefore unenforceable." *Id.* Accordingly, the Court in *Ahlborn* affirmed the judgment of the Eighth Circuit that 42 U.S.C. § 1396p preempts the Arkansas statute at issue. This Court should decline Texas' invitation to overrule *Ahlborn* – an issue that is not presented by the Petition or advocated by any of the parties to this appeal.

Congress has expressly precluded state Medicaid programs from taking from Medicaid beneficiaries the portions of tort settlements that are fairly allocated as payment for pain and suffering, disfigurement, lost wages and other non-medical expense damages. As reflected by the *Ahlborn* decision, Congress' directive to States is clear and unambiguous. N.C. Gen. Stat. § 108A-57 violates this express requirement. Accordingly, that statute is preempted by federal law.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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APPENDIX A

42 U.S.C. § 405. Evidence, procedure, and certification for payments

* * * * *

(d) Issuance of subpenas in administrative proceedings

For the purpose of any hearing, investigation, or other proceeding authorized or directed under this subchapter, or relative to any other matter within the Commissioner's jurisdiction hereunder, the Commissioner of Social Security shall have power to issue subpenas requiring the attendance and testimony of witnesses and the production of any evidence that relates to any matter under investigation or in question before the Commissioner of Social Security. Such attendance of witnesses and production of evidence at the designated place of such hearing, investigation, or other proceeding may be required from any place in the United States or in any Territory or possession thereof. Subpenas of the Commissioner of Social Security shall be served by anyone authorized by the Commissioner (1) by delivering a copy thereof to the individual named therein, or (2) by registered mail or by certified mail addressed to such individual at his last dwelling place or principal place of business. A verified return by the individual so serving the subpoena setting forth the manner of service, or, in the case of service by registered mail or by certified mail, the return post-office receipt therefor signed by the individual so served, shall be proof of service. Witnesses so subpoenaed shall be paid the same fees and mileage

as are paid witnesses in the district courts of the United States.

(e) Judicial enforcement of subpenas; contempt

In case of contumacy by, or refusal to obey a subpoena duly served upon, any person, any district court of the United States for the judicial district in which said person charged with contumacy or refusal to obey is found or resides or transacts business, upon application by the Commissioner of Social Security, shall have jurisdiction to issue an order requiring such person to appear and give testimony, or to appear and produce evidence, or both; any failure to obey such order of the court may be punished by said court as contempt thereof.

* * * * *

APPENDIX B

42 U.S.C. § 1396p. Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot

reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

* * * * *

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

* * * * *

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter.

* * * * *

APPENDIX C

42 U.S.C. § 1396q. Application of provisions of subchapter II relating to subpoenas

The provisions of subsections (d) and (e) of section 405 of this title shall apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter, except that, in so applying such subsections, and in applying section 405(*l*) of this title thereto, with respect to this subchapter, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

APPENDIX D

42 U.S.C. § 1396u-6. Medicaid Integrity Program

(a) In general

There is hereby established the Medicaid Integrity Program (in this section referred to as the "Program") under which the Secretary shall promote the integrity of the program under this subchapter by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b).

* * * * *

(c) Eligible entity and contracting requirements

* * * * *

(4) Limitation on contractor liability

The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1320c-6 of this title.

* * * * *

APPENDIX E

42 C.F.R. § 455.202. Limitation on contractor liability

(a) A program contractor, a person, or an entity employed by, or having a fiduciary relationship with, or who furnishes professional services to a program contractor will not be held to have violated any criminal law and will not be held liable in any civil action, under any law of the United States or of any State (or political subdivision thereof), by reason of the performance of any duty, function, or activity required or authorized under this subpart or under a valid contract entered into under this subpart, provided due care was exercised in that performance and the contractor has a contract with CMS under this subpart.

* * * * *

REPLY BRIEF

Supreme Court, U.S.
FILED
DEC 2 8 2012
OFFICE OF THE CLERK

No. 12-98

In the
Supreme Court of the United States

ALBERT A. DELIA, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

E.M.A., A MINOR, BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON, WILLIAM EARL ARMSTRONG and SANDRA ARMSTRONG,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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ARGUMENT

Respondents and their amici, including the United States, fundamentally misconstrue North Carolina's third party recovery statute. They characterize the issue presented as whether the statutory "presumption" as to which part of a settlement represents medical damages must be "rebuttable" so that, on a case-by-case basis, it can be determined whether that "presumption" is correct.

North Carolina's statute does not create a "presumption." Unlike a "presumption" that is imposed after the fact on a settlement, North Carolina's allocation is not an approximation or a guess. The statute can never incorrectly predict the amount attributable to past medical expenses because the parties are required to include in any settlement the exact amount that the Medicaid program must be repaid. In, and only in, circumstances where repayment of the Medicaid lien in full would excessively deplete the recovery received by the Medicaid beneficiary, the statute provides the State's advance agreement to compromise its claim by capping the reimbursement at one-third of the total amount.

The statutory allocation provision at issue is not a "presumption" but instead a condition attached to the receipt of the benefit provided to a Medicaid recipient. The full extent of the State's subrogation claim is not set by the statute but instead is determined by the dollar amount of the Medicaid payments made on behalf of the recipient for necessary medical services. The one-third requirement does not presume or predict

what portion of a damage award represents recovery for past medical expenses; it is only a cap on the amount that must be paid to the State to satisfy the recipient's repayment obligations arising from the Medicaid benefits provided.

The portion allocated for past medical expenses is exact and, by law, that amount cannot be designated for any other purpose. Both Respondents' attacks on the statute and the decision by the Court of Appeals depend upon the "irrebuttable presumption" mischaracterization. Because North Carolina's statute provides *ex ante* instruction to the parties as to what amount they must include in their settlement for past medical expenses, it does not violate the Medicaid Act's anti-lien provision.

Respondents applied for Medicaid benefits when extensive medical services were necessitated by alleged acts of medical malpractice. E.M.A.'s injuries require on-going medical care and treatment, and Medicaid continues to provide necessary skilled nursing care.[1] Respondents' tort action alleging

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[1] Respondents note that because the portion of the settlement released to E.M.A. was placed in a Special Needs Trust she is not "ineligible for Medicaid services." (Resp. Br. 6) Respondents have previously indicated that E.M.A. "receives skilled nursing care that is paid for by the Medicaid program" (J.A. 41), and that E.M.A. "receives skilled nursing care that is paid for by the North Carolina Medicaid program" (Opening Br. Of Appellants ("Open. Br.") 4, 4th Cir. Docket No. 10-1865).

negligence ultimately settled for $2.8 million. At the time of settlement the Medicaid program's payments were in excess of $1.9 million. Respondents have resisted North Carolina's right to recoup the portion of the settlement proceeds specified in N.C. Gen. Stat. § 108A-57, North Carolina's third-party recovery statute. Respondents assert that the statutory recovery amount exceeds the portion of the settlement that was intended as compensation for the recipient's past medical expenses.

North Carolina's statute structures a Medicaid recipient's recovery of compensation from a third-party for which Medicaid has provided past medical care. The statute prescribes the damages that are available to the recipient by defining the amount that must be used to satisfy the recipient's duty to repay the State for Medicaid's provision of necessary medical services. It further provides that this repayment obligation is a priority that must be satisfied before the recipient can recover other types of damages.

There is not an "allocating away" of the recipient's property because state law permits a settlement only if the Medicaid recipient designates the mandated amount to allow the State to recoup a portion of its payments for medical services. Additionally, North Carolina's statute sets forth the State's agreement to a compromise of its claim for full reimbursement for past medical services under specific circumstances. It provides – in advance of the initiation of any lawsuit or a discussion of settlement – mandatory allocation rules

that all parties can rely upon as they assess their legal status and obligations.

Enforcement of North Carolina's statutory provision furthers the purpose of the third-party recovery mandate set forth in the Medicaid Act. Furthermore, the provision provides advance notice of the applicable ground rules to all parties, thereby promoting consistency and predictability in the allocation process. N.C. Gen. Stat. § 108A-57 allows the State to recover a defined amount from any settlement to recoup a portion of the monies paid for necessary medical services.

A. North Carolina's Statute Is Not Inconsistent With This Court's Decision in *Ahlborn*.

The decision in *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006) did not reach and expressly left open the issue of how a state should determine what portion of a Medicaid recipient's damage settlement represents reimbursement for medical expenses. Indeed, as the United States expressly recognizes, "the question of how to apportion a settlement into payments for medical costs and payments for non-medical costs was not presented" in *Ahlborn*. (U.S. Br. 4-5)

The dispositive holding of *Ahlborn* is that the third-party recovery exception to the anti-lien provision "is limited to payments for medical care." 547 U.S. at 285. As observed by the United States,

> [t]he operation of the anti-lien provision in *Ahlborn* was straightforward. The State and the beneficiary had stipulated to the portion of the settlement – approximately $35,000 - that represented payment for medical expenses. 547 U.S. at 280-281. With the proper apportionment thus determined, the anti-lien provision prohibited the State from seeking to recover more than the medical-payments portion of the settlement. *Id.* at 285. In light of the parties' agreement, the Court had no need to address the methods a State might permissibly use to determine a proper allocation in the first place. *Id.* at 288.

(U.S. Br. 13 (emphasis supplied))

Respondents and their amici insist, however, that a case-by-case resolution of the amount that was "intended to compensate" the plaintiff for past medical services or that is "fairly attributable" to such damages is required by *Ahlborn* to avoid conflict with the Medicaid Act's anti-lien provision. These broad characterizations of the scope and content of the *Ahlborn* decision cannot withstand analysis.

1. Respondents repeatedly rely upon language describing the question for decision as whether Arkansas could "lay claim to more than the portion of Ahlborn's settlement that represents medical expenses." 547 U.S. at 280 (emphasis supplied). (Resp. Br. 10, 12, 14, 15, 16) Further conclusions are premised upon the phrase referencing the portion of

the settlement proceeds that "properly are designated as payments for medical costs." 547 U.S. at 288 (emphasis supplied). However, in proper context, the statements refer to a stipulation by the Medicaid lienholder as a party to the federal court action which conclusively answered the underlying factual question.[2]

2. Errors arise from Respondents' mischaracterization of the following guidance in *Ahlborn* concerning ways to avoid the risk of settlement manipulation when circumstances do not include the Medicaid lienholder's stipulation as to medical costs:

> Even in the absence of such a postsettlement agreement, though, the risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.

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[2] Respondents' criticism of Petitioner's and the North Carolina Supreme Court's reliance on the "controlling stipulations" to define the scope of the *Ahlborn* decision (Resp. Br. 11, 19) is misplaced. The form of the determination– a stipulation – was not dispositive. Instead, the relevance and importance derives from the parties' binding agreement establishing what portion of the settlement represented payment for medical expenses – an agreement that included the Medicaid lienholder, the Arkansas DHHS.

547 U.S. at 288. First, Respondents claim that the North Carolina statute cannot be described as an "advance agreement" as to the amount of the State's recovery from a settlement because the referenced language contemplates an allocation "agreement between the Medicaid beneficiary and the state Medicaid program." (Resp. Br. 23 n.11) Plainly, the cited portion of this Court's decision references actions that the State can take to protect its interest to avoid unilateral action by the Medicaid recipient to diminish or eliminate recoupment of payment for past medical services. Second, Respondents' claim that the Court "expressly stated" that when the recipient and the state Medicaid program disagree the allocation of damages "should" be resolved in a judicial proceeding (Resp. Br. 29) misapplies the referenced language. In proper context, a judicial determination is a permissible but not a mandatory method to guard against settlement manipulation.[3]

3. Respondents assert that because the facts of the case do not "raise even the hint of settlement

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[3] Nor does this language support the claim by the United States that "in the Medicaid context, the State may not decree the portion to which it is entitled without affording the beneficiary some opportunity to challenge that assertion." (U.S. Br. 21) The Government offers no basis upon which to engraft a hearing requirement onto "rules and procedures for allocating tort settlements" that "might be employed to meet concerns about settlement manipulation." 547 U.S. at 288 n.18.

manipulation" and because "there was no allocation in the settlement" (Resp. Br. 32), the case is not "an appropriate vehicle for addressing settlement manipulation" (Resp. Br. 32-33). However, Respondents claim the Medicaid recipient's reimbursement obligation must be "proportionally reduced" because the recovery was less that the full amount of damages (Resp. Br. 15 n.5), and argue that "[t]he State should not be immune from sharing . . . proportionally" in the substantial reduction of the recipient's recovery which resulted from "the lack of available insurance" (Resp. Br. 18).

Respondents' call for the concept of proportionality to control issues of settlement allocation raises the potential for damage manipulation to the detriment of the State's reimbursement claim. (Pet. Br. 31-33) Indeed, in a different context the United States has recently maintained that under a pro rata theory, "[n]ot only would the apportionment percentages be subject to manipulation, but so too would the hypothetical total losses to the participant, which might bear little or no relation to the amount the plan paid and for which it seeks reimbursement." (U.S. Br. in *U.S. Airways v. McCutchen*, at 20-21, U.S. Supreme Court Docket No. 11-1285)

Furthermore, Respondents' current insistence that there was "no allocation in the settlement" is diametric to their previous representation that the state court judge "allocated the settlement between E.M.A. and her parents, awarding 88 percent of the

settlement to E.M.A., all of which was to be placed in a special needs trust to care for her medical and other needs during her lifetime. . . . He allocated 12 percent of the settlement to the parents for their claim for medical expenses through age 18 and Mrs. Armstrong's emotional distress." (Open. Br. 5-6)[4]

North Carolina's statute provides advance notice to all parties as to how to apportion a settlement for repayment for Medicaid's medical costs. The holding of *Ahlborn* is then applied to the apportioned settlement, with the State's recovery explicitly limited to the amount representing the recovery for past medical services. There is no inconsistency between this Court's prior decision and the terms of North Carolina's third-party recovery statute.

B. North Carolina's Third-Party Recovery Statute Does Not Contravene The Medicaid Act's Anti-Lien Provision.

North Carolina's third-party recovery statute apportions in advance of a settlement or judgment the

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[4] This claimed allocation, in combination with the argument that "[t]he claim for past medical expenses – those expenses for which the State is seeking reimbursement – belongs completely to E.M.A.'s parents." (Open. Br. 9), led to Respondents' previous assertion that "the proper outcome for this case is for the State of North Carolina to be awarded $112,000 – which amounts to one-third of the recovery for E.M.A.'s parents – from those funds held in trust" (Open. Br. 19).

medical services portion of any recovery of damages by a Medicaid recipient from a tortfeasor. (Pet. Br. 23-26) It provides a means of calculating the portion of any settlement that, by definition, represents payment for medical expenses and "then forbids the State from imposing a lien on the remainder of the settlement." (Pet. App. 82a) Respondents and their amici posit that the statute must be stricken because the end result of the North Carolina's procedure does not equate with the amount the parties "intended to compensate" for Medicaid's provision of medical services.

1. Respondents' fundamental mistaken premise is that North Carolina has established a statutory presumption that past medical expenses will account for one-third of tort settlements. They then argue that the "facts of the present case illustrate how the irrebuttable presumption" (Resp. Br. 16), results in the State recovering more than it should because

> it is not reasonable for Petitioner to assume that of the $2.8 million settlement, the sum of $933,333.33 was being paid for past medical expenses and the remaining sum of $1,866,666.67 was intended to suffice as payment for the entirety of E.M.A.'s non-medical damages, as well as legal fees and costs.

(Resp. Br. 17)

Respondents' position mischaracterizes the statute. It does not create a presumption as to how

settlements entered into by the parties to a medical malpractice action usually are allocated, or how the recovery in this case was actually allocated. Rather, the statute provides advance guidance as to the amount that must be set aside for repayment of the past medical services provided by the State before a plaintiff can recover for other categories and types of damages. The statute places limits on how settlements are allowed to be allocated. And the one-third provision in the statute is not an estimate of the medical expense component of the Medicaid recipient's settlement; it is instead a cap on the amount the State will receive in satisfaction of its lien for the provision of past medical services pursuant to its right to recover from third-party payments

Respondents further attack North Carolina's procedure as "arbitrary" because "the statute recognizes that the amount of medical expenses will frequently be less than one-third of the plaintiff's total damages." (Resp. Br. 26) Again, this argument confuses the concepts of allocation with presumption. The legislature did not create an internally contradictory provision arising from a presumption that payment for medical services comprise one-third of the total settlement. Instead, the statute imposes in advance a requirement that the State's medical services lien be accorded a repayment priority and sets forth a cap on the amount that must be allocated to that obligation. Respondents have not explained why such an allocation is invalid because it is based on two measurements, with the lesser one controlling.

2. Respondents' brief reflects further fundamental analytical flaws regarding the State's right of recovery from a Medicaid recipient's tort claim settlement.

a. First, they conflate the damages being sought with the recovery actually received, and imply that a proportional reduction in all categories of damages claimed is the appropriate methodology to govern the allocation of the recipient's settlement. While the plaintiffs' evidence indicated that "E.M.A. incurred damages in excess of $42 million as a result of her physician's malpractice" (Resp. Br. 3)[5], the parties to the negligence action reached an agreement to settle all claims for the sum of $2.8 million (Resp. Br. 4-5). Once the actual recovery is reached, the dollar amount of the different categories for which compensation is being sought is relevant only if Respondents are advocating that the recovery is to be subdivided on a proportional basis. That is because

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[5] Respondents rely upon a report developed by a life care planner which was used by an economic expert to determine the projected cost of the products and services needed by E.M.A. over her lifetime as a result of her injuries. (J.A. 91-112) In the opinion of the economic expert, the present value of such necessary goods and services was approximately $41 million, with over $37 million of that amount for "skilled nursing care." (J.A. 112) As such, Respondents damage claim is largely comprised of anticipated future medical expenses without any consideration of whether Medicaid will continue to provide such services.

the third-party recovery provision, N.C. Gen. Stat. § 108A-57(a), establishes the Medicaid recipient's obligation to repay the State out of the "proceeds obtained on behalf of the beneficiary." (Pet. App. 114a)

b. Second, Respondents equate the statutory compromise of the State's reimbursement right with the full value of Medicaid's claim for the provision of necessary medical services. Respondents claim that they were "forced to give up a substantial portion of [their] recovery simply because [the] treating physician was not sufficiently solvent to pay [the] claim in full," and argue that "[t]he State should not be immune from sharing in that loss proportionally." (Resp. Br. 18)[6] As demonstrated by the circumstances of this case, the State's statutory agreement to cap its recoupment at one-third of the total settlement

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[6] Respondents take out of context the discussion at pages 31-32 of the Petitioner's Brief of reasons why use of a proportional analysis or application of a pro rata reduction formula creates opportunities for settlement manipulation. (Resp. Br. 18 n.8) The same concerns for reducing "the State's recovery by inflating the amount of intangible damages sought" by the Medicaid recipient were recognized by the United States as a disadvantage to a proportional reduction process. (U.S. Br. 31) *See also* U.S. Br. in *U.S. Airways* at 20 (footnote omitted) (use of a "pro rata reduction theory to funds recovered in settlements with third parties would create opportunities for manipulation of the amounts apportioned for different categories of damage").

amount ($933,333.33) represents a substantial discount from full recovery ($1,900,000) – a reduction of almost one million dollars from the uncontroverted value of medical services provided. Respondents' position is that the State's claim must be further compromised by equating it with other components of projected damages.

3. The United States recognizes that North Carolina's statute determines in advance the medical costs portion of a settlement, and that such "[a]llocation rules govern a determination that is antecedent to the operation of the anti-lien provision: how to divide a settlement into a medical portion (recoverable) and a nonmedical portion (unrecoverable because it is the beneficiary's property)." (U.S. Br. 13) However, even though "state tort law determines a personal-injury plaintiff's substantive entitlement to damages in the first instance" (U.S. Br. 20), the United States asserts that North Carolina's statute "does not govern the damages a plaintiff may receive for particular claims or the procedures applicable in tort actions" (U.S. Br. 20). The United States maintains that N.C. Gen. Stat. § 108A-57 is therefore "preempted," not because it is impossible to comply with both the federal and state law but instead because it "frustrates the operation of the anti-lien provision" of the Medicaid Act. (U.S. Br. 16)

Characterizing the effect of N.C. Gen. Stat. § 108A-57 as specifically circumventing the anti-lien provision (U.S. Br. 21-22) disregards the legislative

context demonstrating that the third-party recovery statutes are consistent with North Carolina's longstanding exercise of its broad authority over tort actions. As previously shown (Pet. Br. 20-23), the concepts and policy considerations underlying the requirement that up to one-third of a tort settlement must be allocated for payment of past medical services is not unique to cases involving Medicaid recipients; instead, it is wholly consistent with legislation first adopted in 1935 creating a lien on personal injury recoveries in favor of the providers of medical supplies or services. *See* N.C. Gen. Stat. §§ 44-49 and 44-50 (2011). And, because the statute limits the State's recovery to the defined amount of any recovery attributable to the costs of past medical services, North Carolina' statute avoids violating the anti-lien provision in the way the Arkansas statute did in *Ahlborn*.[7]

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[7] Both Respondents and the United States argue that even though North Carolina's statute defines the portion of a Medicaid recipient's tort recovery that must be allocated for repayment of past medical services at a maximum of 33%,there is no reason why a State could not prospectively allocate 90% or 100% to medical costs. (Resp. Br. 25; U.S. Br. 22) Such a statute would not be preempted by the anti-lien provision because, by definition, the amount of the State's lien would be limited to monies that the recipient must allocate to past medical costs. However, a 90% or 100% requirement would raise the issue of whether the provision was specifically targeted at Medicaid recipients with an intent to evade the anti-lien provision.

North Carolina's statute is categorically different from the statute at issue in *Ahlborn* which the Court found "squarely conflicts with the anti-lien provision of the federal Medicaid laws." 547 U.S. at 280. The Arkansas statute totally overrode the anti-lien provision's requirement that a State's recovery of damages from a third-party be "limited to payments for medical care," *id.* at 285, because the asserted recovery exceeded the amount of the agreed-upon settlement that Arkansas had stipulated "represents compensation for medical expenses" *id.* at 280.

By contrast, N.C. Gen. Stat. § 108A-57 defines in advance the portion of a Medicaid recipient's settlement that represents payment for medical expenses "and then forbids the State from imposing a lien on the remainder of the settlement." (Pet. App. 82a) This advance directive by the State provides the parties with the precise amount that must be allocated to Medicaid's medical expenses in order to satisfy the State's lien. The Medicaid lien component necessarily becomes part of the fabric of the settlement because the parties know in advance the medical expenses portion because it is defined by statute.

C. A Post-settlement "True Value" Hearing Is Not Required By The Medicaid Act Nor Is The State Required To Directly Participate In The Underlying Tort Action.

Ascertainment of the bona fide "true value" of a personal injury lawsuit such as the medical malpractice action at issue here is not a realistic and

achievable requirement. (Pet. Br. 27-30) How to discern what portion of which category of damages was compromised by how much in order to arrive at the amount of the settlement is an inexact and subjective process at best. Here, Respondents maintain that their $42 million damage action was settled for a gross amount of $2.8 million for only one reason: because the "treating physician was not sufficiently solvent to pay [the] claim in full." (Resp. Br. 18) An after-the-fact construct of a purported allocation of the actual recovery between the various categories of damages would, as this Court has observed in a different context, "bear[] some resemblance . . . to slicing a shadow." *Container Corp. of Am. v. Franchise Tax Bd.*, 463 U.S. 159, 192 (1983).

1. Indeed, Respondents and their amici avoid mentioning the "true value" concept and instead embrace broadly a process in which the State "negotiate[s] with Medicaid beneficiaries to reach a fair and appropriate allocation of damages." (Resp. Br. 29)[8] And the United States suggests judicial or

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[8] Respondents expressly state that at any post-settlement hearing "the state Medicaid program would not be bound by a settlement agreement in which it was not a party." (Resp. Br. 29 n.13) *See also* Resp. Br. 32 (any settlement agreement crafted by the parties to allocate away the interests of the state Medicaid program "would not be binding on the State"). This position directly conflicts with the position of Respondents' amicus party when it asserts that the State cannot disregard allocations by the parties.

administrative hearings as one option within the scope of the "broad discretion" and "considerable leeway" of the States to develop methods of allocating settlements. (U.S. Br. 27) However, neither Respondents nor the United States have shown how a requirement for a post-settlement hearing as mandated by the Fourth Circuit is grounded in the Medicaid Act's anti-lien provision.

That various other states utilize post-settlement procedures to allocate between medical and nonmedical damages does not demonstrate that such processes are required or effective. Arguing that a State "could" or even "should" enact such a procedure does not establish that a State "must" provide for a case-by-case review to comply with the Medicaid Act's anti-lien provision. Nor does the observation that "[s]ixteen States and the District of Columbia explicitly provide the opportunity for a post-settlement" hearing (U.S. Br. 28) provide any indication that such procedures will not become mini-trials, involving complex and costly proceedings in which liability theories and defenses would have to be addressed and expert testimony required as to the

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(Fed. of Def. Br. 16) As previously explained, a recipient's designation of the amount of damages attributable to past medical expenses inadequately protects the State's lien and cannot override the statutory apportionment. (Pet. Br. 30-33)

various components of damages.[9] Indeed, as recently observed in a pending ERISA case, apportionment of damages between medical expenses and non-medical matters can be "costly and complex to adjudicate." (U.S. Br. in *U.S. Airways* at 21)

The inherently disadvantaged position of the State at such post-settlement hearings is tacitly acknowledged by the United States when it suggests that while the State may "institute procedural protections" requiring disclosure of pertinent information to allow meaningful participation in the hearing, the "State even then might not be on an equal footing with the beneficiary and the tortfeasor or its insurer," because such measures can only "mitigate the disadvantage." (U.S. Br. 32) It is of little solace that States can protect their interests by "provid[ing]

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[9] The post-settlement hearing here would be significantly different from the Workers' Compensation lien allocation proceedings referenced by Respondents' amicus. (Am. Assoc. for Justice Br. 17-24) The North Carolina Workers' Compensation Act was created "to ensure that injured employees receive sure and certain recovery for their work-related injuries without having to prove negligence." *Whitaker v. Town of Scotland Neck*, 357 N.C. 552, 556, 597 S.E.2d 665, 667 (2003). Division of the monies at issue primarily involves how much to allocate for future wages as provided for by a statutory formula. Moreover, if the employee sues a third party, the employer is not at a comparative disadvantage with the beneficiary concerning relevant information.

general guidance that the allocation should be equitable to both sides." (U.S. Br. 31)[10]

2. Nor must or should a State initiate its own action to enforce its subrogation rights to recover for the past payment for necessary medical services by Medicaid, as advocated by Respondents' amici (Am. Assoc. for Justice Br. 23; Fed. of Def. Br. 7) Indeed, as observed by the United States, States have "the discretion to stay out of the litigation and resolve allocation issues after the beneficiary and the third party have settled the beneficiary's claim." (U.S. Br. 28)

While North Carolina could have intervened in Respondents' malpractice action or brought its own suit, any recovery by the State necessarily requires the establishment of liability before the obligation of a third-party to pay for past medical services would arise. As previously noted by the United States, "[n]othing in the statutory text indicates that independent pursuit of an assigned claim is the sole statutorily permitted mode of recovery," and, because

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[10] Instead, the more persuasive analysis is the prior indication by the United States that "post hoc hearings are not a sufficient remedy in this instance." (U.S. Br. in *Ahlborn* at 17 n.7 ("[T]he hearing would have to answer how unproven personal injury claims have been subdivided into different manifestations of that injury, as discounted by proof difficulties and myriad other, subjective and individualized considerations that prompt plaintiffs to forego trials."))

of the dependence on the Medicaid recipient for evidence establishing liability, a State "could reasonably conclude that a beneficiary will be most effective in establishing liability when the beneficiary's own separate claims for relief are also on the line." (U.S. Br. in *Ahlborn* at 16)

Insistence on the State bringing its own action could have significant consequences on the recipient's ability to recover. The State would be pursing the full amount of its own claim – here, $1.9 million. The one-third statutory cap provision of N.C. Gen. Stat. § 108A-57 would not apply since it is applicable only to "proceeds obtained on behalf of the beneficiary." (Pet. App. 114a) Thus, in circumstances where there is a finite amount that can be recovered–here, $2.8 million because of malpractice insurance limits – the State's independent action could consume most if not all of the available monetary resources before the beneficiary's damage claims could be considered.

Additionally, the various claims that the State does not bear any portion of the litigation costs, including attorneys fees and that "the amount of the State's lien is not adjusted to account for those fees and costs," (Resp. Br. 17 n.7) cannot withstand analysis. It is true that the plaintiff pays her attorneys' fees. However, the statutory history of North Carolina's third-party recovery provision demonstrates that shielding two-thirds of any recovery was expressly intended to allow the plaintiff and her attorneys to divide the recovery in accordance with

their contract.[11] Furthermore, utilization of a statutory formula promotes appropriate policy goals because "a case-by-case determination of the medical expense portion of settlements could lead to variable results and increased litigation due to inconsistency in outcomes." *Andrews v. Haygood*, 362 N.C. 599, 604, 669 S.E.2d 310, 314 (2008), *cert. denied sub nom. Brown v. North Carolina Dep't of Health and Human Servs.*, 129 S. Ct. 2792 (2009).

Here, the State's claim has been compromised by almost one million dollars pursuant to the statutory provision capping recovery at one-third of the total recovery. The apparent purpose of a post-settlement hearing would be to effect a further reduction in the

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[11] North Carolina's third-party recovery statute previously provided for the payment of attorneys' fees, up to one-third of the recovery, before payment to the State and to the beneficiary. In *North Carolina DHHS v. Weaver*, 121 N.C. App. 517, 466 S.E.2d 717, disc. *rev. denied*, 342 N.C. 896, 467 S.E.2d 905 (1996), the North Carolina Court of Appeals held that N.C. Gen. Stat. § 108A-57 was not intended to regulate the contract between the Medicaid beneficiary and her attorney nor to limit the attorney to one-third of the recovery proceeds. The statute was thereafter amended to its present form, preserving the one-third cap on the amount of reimbursement to Medicaid but allowing the remaining two-thirds to be divided between the beneficiary and her attorney in accordance with their contract.

amount apportioned to repayment for past medical expenses.[12]

D. The Newly Announced Position Of The United States Concerning North Carolina's Third-Party Recovery Procedure Is Not Entitled To Deference.

North Carolina's third-party recovery procedure has operated with the knowledge of and the approval of the Centers for Medicare & Medicaid Services ("CMS"). (Pet. Br. 33-36) Pursuant to 42 U.S.C. § 1396a(a)(25)(A)(ii), CMS has a duty to monitor, on an ongoing basis, a state's plan for pursuing claims against third-parties. And yet, while North Carolina's statute has been essentially the same since 1996, CMS has never provided any indication that they disapprove of the procedure utilized in North Carolina, either before or after the decision in *Ahlborn*. Instead, in official correspondence to a member of Congress, CMS has stated that North Carolina's third-party recovery statute is not in "conflict with CMS' guidance." (Pet. App. 142a)

The United States now purports to disavow any statements made by CMS in the 2009 congressional

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[12] Neither Respondents nor their amici broach the possibility that the amount of attorneys fees, which can range from 33% to 40% of the gross recovery (Fed. of Def. Br. 10), is on the table in a post-settlement analysis seeking a "fair" allocation of the proceeds of the lawsuit when a tortfeasor's "limited resources" constrains full recovery.

reply memo, declaring that the response was "incorrect," and asserting that "[t]he Secretary's interpretation of the relevant provisions of the Medicaid Act and the 2006 CMS Guidance Memo is reflected in this brief." (U.S. Br. 25) The 2006 Guidance Memo is later described as "formal guidance" which sets forth "CMS's official advice to the States concerning permissible methods of recovering costs after *Ahlborn*." (U.S. Br. 26)

The federal government's newly minted re-interpretation of CMS guidance concerning North Carolina's third-party recovery rights and duties is not entitled to deference and is not persuasive. When a position of the United States has been developed *pendente lite*, the usual requirement for deference to regulatory interpretations made by an agency concerning the statute it administers has no application. *Atkins v. Parker*, 472 U.S. 114, 133 (1985). And "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view," *INS v. Cardoza-Fonseca*, 480 U.S. 421, 448 n.30 (1987) (quoting *Watt v. Alaska*, 451 U.S. 259, 273 (1981)). Furthermore, an agency's ultimate conclusion as to whether a state law should be preempted is not entitled to deference. *PILVA, Inc. v. Messing*, 131 S. Ct. 2567, 2575 n.3 (2011).

Here, the 2006 CMS Guidance Memorandum describes *Ahlborn* as holding that "to the extent State

laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws." (U.S. Br. 23; Pet. App. 127a (emphasis supplied)) The emphasized key factor differentiates the circumstances presented here from those in *Ahlborn*: whereas Arkansas had stipulated to the portion of the third-party recovery representing payment for past medical services, North Carolina defines that amount by statute in advance of any lawsuit or settlement. The 2006 Guidance Memorandum further provides that States may enact "laws which provide for a specific allocation amongst damage[s]" (U.S. Br. 24; Pet. App. 129a), and that "a State could enact laws which give priority to the repayment of medical expenses" (U.S. Br. 24 n.5; Pet. App. 130a).

North Carolina's statutory provisions comport with the concepts outlined in the 2006 CMS Guidance Memorandum as well as the approaches recognized in *Ahlborn*: they establish criteria regarding how tort settlements are to be allocated when the Medicaid program has paid a recipient's medical expenses and they provide an advance agreement that the State will compromise its priority claim to reimbursement if the amount of the Medicaid lien exceeds one-third of the total recovery. Both the United States' attempt to diminish the significance of the 2009 congressional correspondence as merely a "workday advice letter" (U.S. Br. 25), as well as Respondents' dismissive assertion that the "letter is nothing more than an

effort by an HHS employee to appease the concerns of a Congressman" (Resp. Br. 34), miss the point. The appropriate consideration is not that the letter itself is entitled to any particular deference, but rather that it reflects the invariable position that North Carolina's third-party recovery statute is invariable with the 2006 CMS Guidance Memorandum.

North Carolina's statutes balance the tension between the Medicaid Act's third-party recovery and anti-lien provisions. Recipients are required to structure their settlement agreements to reimburse the State for the medical services it provided from the monies recovered from a liable tortfeasor. The portion attributed to repayment for past medicals is capped at one-third of the total recovery, thereby ensuring that the recipient has access to the majority of the settlement. Thus, North Carolina's procedures reflect the policy considerations previously articulated by the United States: "Medicaid's status as the payer of last resort can only be preserved . . . if Medicaid's third-party liability provisions are stringently enforced. . . . . Otherwise, Medicaid becomes a program of short-term financial expedience that enables long-term financial windfalls, rather than a payer of last resort for the truly indigent." (U.S. Br. in *Ahlborn* at 11)

CONCLUSION

For the foregoing reasons, and those stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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December 2012

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AMICUS CURIAE BRIEF

No. 12-98

In the Supreme Court of the United States

ALBERT A. DELIA, SECRETARY, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

E.M.A., A MINOR, BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENTS

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QUESTION PRESENTED

Under North Carolina law, if the state Medicaid program pays for a Medicaid beneficiary's medical assistance and the beneficiary later recovers from a third party that is legally liable to pay for the same care or services, the State is entitled to recover from the beneficiary either the total amount of the medical assistance the State paid, or one-third of the gross amount the beneficiary recovered, whichever is lower. The beneficiary has no opportunity to rebut the presumption that up to one-third of the gross amount of her settlement represents payment for medical expenses for which the state Medicaid program paid.

The question presented is whether this irrebuttable state-law presumption is inconsistent with the Medicaid statute's anti-lien provision, which provides that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." 42 U.S.C 1396p(a)(1).

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In the Supreme Court of the United States

No. 12-98

ALBERT A. DELIA, SECRETARY, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

E.M.A., A MINOR, BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENTS

INTEREST OF THE UNITED STATES

This case concerns the third-party liability provisions of the federal Medicaid Act, 42 U.S.C. 1396 *et seq.*, which represent a source of compensation for that program at both the federal and state levels. Congress has vested the Secretary of Health and Human Services with broad authority to administer the Medicaid program. 42 U.S.C. 1302. The question presented directly implicates the Secretary's interpretation and implementation of the Medicaid statute.

STATEMENT

1. a. The Medicaid Act (Act), enacted in 1965 in Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*,

establishes a cooperative federal-state program to fund medical care for individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. 1396-1 (Supp. III 2009); see *Arkansas Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268, 275 (2006). Medicaid is administered by the Secretary of Health and Human Services (Secretary), who exercises her authority through the Centers for Medicare & Medicaid Services (CMS). *Ibid.* The Federal Government pays a significant portion of the costs the States incur for patient care. See 42 U.S.C. 1396d(b) (Supp. IV 2010). "In return, participating States are to comply with requirements imposed by the Act and by the Secretary of Health and Human Services." *Atkins* v. *Rivera*, 477 U.S. 154, 156-157 (1986); see generally 42 U.S.C. 1396a (2006 & Supp. IV 2010).

Medicaid limits eligibility to certain categories of individuals who have extremely limited resources available to pay for medical care. See 42 U.S.C. 1396a(a)(10) (2006 & Supp. IV 2010). Because state and federal resources are not unlimited, "Medicaid is intended to be the payer of last resort," and various provisions require that other available resources must be used before an individual is deemed eligible or before Medicaid pays for an individual's care. S. Rep. No. 146, 99th Cong., 1st Sess. 312 (1985); see, *e.g.*, 42 U.S.C. 1396*o* (2006 & Supp. IV 2010). At the same time, the Act attempts to ensure that its provisions do not have the unintended effect of exhausting already-limited resources that are necessary for an individual's maintenance. See, *e.g.*, S. Rep. No. 404, 89th Cong., 1st Sess. 80 (1965) (States must ensure that cost-sharing provisions "protect the income and resources of the individual needed for his maintenance").

b. At times, an individual's need for Medicaid benefits arises from circumstances that render third parties (such as a tortfeasor or insurance company) liable for the costs of the medical care. S. Rep. No. 744, 90th Cong., 1st Sess. 184 (1967). When a state Medicaid program pays medical costs for which a third party may be liable, the Medicaid Act requires the State to "take all reasonable measures to ascertain the legal liability of third parties * * * to pay for care and services available under the plan." 42 U.S.C. 1396a(a)(25)(A). "[I]n any case where such a legal liability is found to exist," and "the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery," the State must "seek reimbursement for such assistance to the extent of such legal liability." 42 U.S.C. 1396a(a)(25)(B).

To facilitate its ability to obtain reimbursement when third parties are liable, the State must have "in effect laws under which * * * the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services." 42 U.S.C. 1396(a)(25)(H). The state plan must also provide that a Medicaid beneficiary must "assign the State any rights * * * to payment for medical care from any third party." 42 U.S.C. 1396k(a)(1)(A). In addition, the State must require beneficiaries to "cooperate" with the State in identifying and pursuing claims against third parties. 42 U.S.C. 1396k(a)(1)(C).

c. These third-party reimbursement provisions are qualified by the Medicaid Act's "anti-lien" provision, which states that "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." 42 U.S.C 1396p(a)(1). The anti-

lien provision is intended to "protect the individual and his spouse from the loss of their property, usually the home, during their lifetime." S. Rep. No. 1856, 86th Cong., 2d Sess. 8 (1960) (discussing anti-lien provision in predecessor statute).

In *Ahlborn*, this Court held that the anti-lien provision prohibits States from seeking reimbursement from third-party payments to a beneficiary that do not represent compensation for medical expenses. 547 U.S. at 283. The State of Arkansas had paid $215,000 in medical assistance on behalf of Ahlborn, a Medicaid recipient who subsequently obtained a $550,000 tort settlement. Although the State and Ahlborn stipulated that only $35,000 of the settlement represented compensation for medical expenses, see *id.* at 274-275, the State argued that it was entitled to recover from Ahlborn's settlement the entire $215,000 the State had paid on Ahlborn's behalf. The Court rejected that argument, reasoning that the State's right to seek third-party reimbursement is an "exception" to the anti-lien provision's otherwise unqualified prohibition against seeking recovery out of a Medicaid recipient's property. *Id.* at 284. Because the third-party reimbursement provisions require the State to seek recovery only "to the extent of" a third party's liability for the medical care paid for by Medicaid, 42 U.S.C. 1396a(a)(25)(A)-(B), the Court concluded that a State may recover only those third-party payments that represent "payments for medical care." *Ahlborn*, 547 U.S. at 285.

In so holding, the Court rejected the argument that a blanket rule requiring "full reimbursement" of the amount that the State had paid was necessary to prevent settlement manipulation. *Ahlborn*, 547 U.S. at 288. Although the question of how to apportion a settlement

into payments for medical costs and payments for non-medical costs was not presented, the Court acknowledged the risk that Medicaid beneficiaries might attempt to "allocate away" the State's reimbursement interest. *Ibid.* The Court suggested that States could address such concerns by "adopt[ing] special rules and procedures for allocating tort settlements." *Id.* at 288 & n.18.

2. As a participant in the federal Medicaid program, North Carolina has established a statutory framework governing its rights to reimbursement when a third party is liable for medical expenses paid by the State. See N.C. Gen. Stat. §§ 108A-57, 108A-59 (2011). Section 108A-57(a) provides that "the State * * * shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance." Section 108A-59(a) provides that "by accepting medical assistance, the recipient shall be deemed to have made an assignment to the State of the right to third party benefits * * * to which he may be entitled."

Section 108A-57 also specifies that in all cases, the State is entitled to reimbursement of the lesser of the full amount that it paid in Medicaid benefits or one-third of the gross settlement amount. Specifically, "[a]ny attorney retained by the beneficiary of the assistance shall," out of any judgment or settlement, "distribute to the [State] Department [of Health and Human Services] the amount of assistance paid by the Department on behalf of * * * the beneficiary, * * * but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered." N.C. Gen. Stat. § 108A-57(a).

3. Respondent E.M.A. was severely injured at birth. As a result, she is deaf, blind, and suffers from mental

retardation and a seizure disorder. The North Carolina Medicaid program paid more than $1.9 million of respondent's medical expenses. Pet. App. 3a, 5a.

In a state-court medical malpractice action, respondents—E.M.A. and her parents—sought damages on behalf of E.M.A. for her physical and developmental injuries, lost wages, pain and suffering, and future medical expenses, and on behalf of E.M.A.'s parents for past medical expenses, future medical expenses, and their own emotional distress. Pet. App. 6a-7a. In November 2006, the state court approved a settlement of approximately $2.8 million. *Id.* at 3a, 6a-7a. Neither the parties nor the court allocated the settlement funds among the distinct claims or categories of damages. *Id.* at 8a. The court ordered the parties to place the sum necessary to satisfy the State's entitlement under Section 108A-57 into a court account until the amount of the lien could be "conclusively judicially determined." J.A. 87; Pet. App. 8a-9a. Because the amount paid by the State in Medicaid benefits was more than one-third of the gross settlement, the parties placed one-third (approximately $933,000) into the account. *Id.* at 9a.

In December 2006, North Carolina's Department of Health and Human Services (the State) moved to intervene in the medical-malpractice action in order to assert its right to reimbursement. Shortly thereafter, respondents brought this action under 42 U.S.C. 1983 in federal district court. Pet. App. 9a. The state court ultimately denied the State's motion to intervene because the court had already approved the settlement. Pet. Br. 10.

4. In their complaint in this action, respondents asserted that North Carolina's statutory lien framework is inconsistent with the Medicaid Act's anti-lien provision

"to the extent that [it] allow[s] [the State] to assert a lien on compensation for damages other than medical expenses." J.A. 23; Pet. App. 9a. Respondents sought, among other things, a determination of the proper amount of the lien and a declaration that the North Carolina statutes are preempted. Pet. App. 9a-10a.

The district court held that North Carolina's statutory lien is consistent with the anti-lien provision as interpreted in *Ahlborn*. Pet. App. 71a-85a. *Ahlborn*, the court recognized, held that "when there has been a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement," the anti-lien provision prohibits the State from recovering more than that amount. *Id.* at 81a. But the court held that Section 108A-57 "essentially defines" the portion of the settlement that constitutes payment for medical expenses in the first place, thereby "avoid[ing] the conflict at issue in *Ahlborn*." *Id.* at 81a-82a. The court therefore granted summary judgment to the State. *Id.* at 85a.

5. The court of appeals reversed. Pet. App. 1a-70a. The court held that North Carolina's "one-third cap * * * does not satisfy *Ahlborn* insofar as it permits [petitioner] to assert a lien against settlement proceeds intended (or otherwise properly allocable) to compensate the Medicaid recipient for other claims, such as pain and suffering or lost wages." *Id.* at 42a.

The court of appeals explained that although *Ahlborn* left open the range of procedures by which a State might determine how to allocate a settlement in the absence of a stipulation or other agreement, Pet. App. 51a-54a, *Ahlborn* established that a State may not recover amounts that properly represent payments for nonmedical damages, *id.* at 42a. The court reasoned that the State's right to full recovery or one-third of the

settlement at best reflected a rough approximation of a "typical" apportionment, which beneficiaries had no opportunity to rebut. *Id.* at 20a, 53a. Approving that blanket rule, the court concluded, would confer "unfettered discretion to allocate settlements without regard to the actual portion attributable to medical expenses," even to the point of "allocating 75%, 90% or even 100% of a settlement to medical expenses." *Id.* at 52a-53a (quoting *Tristani* v. *Richman*, 652 F.3d 360, 378 (3d Cir. 2011)). The court found support for its conclusion in a 2006 post-*Ahlborn* memorandum issued by CMS, which explained that States may not recover "over and above what the parties have appropriately designated as payment for medical" expenses, although they may "enact laws which provide for a specific allocation amongst damage[s]." *Id.* at 46a-47a (brackets in original).

To comply with *Ahlborn*, the court of appeals held, the State must provide a "process by which settlement proceeds are explicitly allocated or otherwise determined." Pet. App. 49a. Thus, "[i]n the event of a lump-sum settlement, as in this case, the sum certain allocable to medical expenses must be determined, in the absence of a stipulation by the affected parties, by judicial determination or some similar adversarial process." *Id.* at 13a. Because respondents had not been afforded that process, the court of appeals remanded the case "for an evidentiary hearing" to permit the district court to "determine the proper amount of [the State's] Medicaid lien in this case." *Id.* at 55a.

SUMMARY OF ARGUMENT

North Carolina's irrebuttable presumption that the medical-expenses portion of a settlement is equal to the lesser of the amount the State paid or one-third of the gross settlement impedes the operation of the Medicaid

Act's anti-lien provision. It is therefore preempted to the extent it forecloses a beneficiary from demonstrating that the statutory allocation is inappropriate in her case.

I. The anti-lien provision, as interpreted by this Court in *Arkansas Department of Health & Human Services* v. *Ahlborn*, 547 U.S. 268, 284-285 (2006), prohibits States from recovering portions of a lump-sum settlement between a Medicaid beneficiary and a third party that do not represent compensation for medical expenses paid by Medicaid. As a general matter, the portion of a settlement that is appropriately allocated to medical expenses will turn on a number of case-specific factors, including the relative definiteness of, and likelihood of recovering, past medical expenses when compared with other types of damages. In *Ahlborn*, the Court did not address the methods a State might use to determine the portion of the settlement that should be allocated to medical expenses. The Court recognized, however, that States may adopt rules and procedures to guide the proper allocation. *Id.* at 288 n.18.

Although allocation rules govern a determination that is antecedent to the operation of the anti-lien provision—the proper division of a settlement into a medical-expense portion and a nonmedical portion—such rules must be consistent with the anti-lien provision. This Court recognized in *Ahlborn* that preliminary determinations concerning the extent of a beneficiary's property may sometimes circumvent the anti-lien provision by divesting a beneficiary of her property interests before that provision ever comes into play. 547 U.S. at 286 n.16. Thus, a State could "allocate away" the beneficiary's interest in the settlement, *id.* at 288, by "allocating" the full settlement to medical costs.

The North Carolina statute at issue in this case, N.C. Gen. Stat. § 108A-57, frustrates the operation of the anti-lien provision. By providing that the State is always entitled to full reimbursement or one-third of the gross settlement, Section 108A-57 will in some cases overestimate the portion of the settlement that may appropriately be regarded as payment for past medical expenses. The State may not categorically substitute its unilateral determination of the amount to which it is entitled for consideration of individual circumstances in determining the proper allocation.

II. States have a substantial interest in guarding against settlement manipulation by Medicaid recipients and in preventing allocation determinations from consuming limited resources. See *Ahlborn*, 547 U.S. at 288. States therefore have broad discretion to adopt allocation rules and procedures that protect the States' interest in reimbursement while allowing for consideration of case-specific circumstances when necessary. A State may employ various approaches to further these interests, including judicial or administrative allocation hearings. A State may establish principles to guide such hearings, including a rebuttable presumption that a certain portion of the settlement represents medical-expense payments. A State may also intervene in third-party tort actions or settlement negotiations in order to protect its interests. Many States have established procedures like these, demonstrating that it is administratively feasible to provide individualized consideration while effectively preventing manipulation.

ARGUMENT

I. THE MEDICAID ACT'S ANTI-LIEN PROVISION DOES NOT PERMIT NORTH CAROLINA TO ESTABLISH AN IRREBUTTABLE PRESUMPTION THAT UP TO ONE-THIRD OF A MEDICAID BENEFICIARY'S THIRD-PARTY SETTLEMENT REPRESENTS MEDICAL EXPENSES FOR WHICH THE STATE MEDICAID PROGRAM PAID

North Carolina's irrebuttable statutory presumption concerning the amount of a settlement to be allocated past medical expenses is preempted to the extent that it forecloses a Medicaid beneficiary from demonstrating that the statutory allocation is inappropriate in her case. Because N.C. Gen. Stat. § 108A-57 disregards the case- and circumstance-specific nature of settlements, it necessarily will allocate to the State in some cases a portion of the settlement that appropriately should be allocated to elements of damages other than past medical expenses. See *Ahlborn*, 547 U.S. at 288. Section 108A-57 impedes the operation of the anti-lien provision and stands as an obstacle to the accomplishment of that provision's purpose. See *Hines* v. *Davidowitz*, 312 U.S. 52, 67 (1941).

A. States May Not Employ Settlement-Allocation Methods That Effectively Circumvent The Anti-Lien Provision

1. In *Ahlborn*, this Court held that a State's right to seek reimbursement under the Medicaid Act's third-party liability provisions is limited by the anti-lien provision's prohibition against attaching, or placing a lien on, a beneficiary's property. 547 U.S. at 284. The third-party reimbursement provisions, the Court explained, *id.* at 281-282, require the State to seek reimbursement "to the extent of" third parties' liability "to pay for care

and services available under the plan." 42 U.S.C. 1396a(a)(25)(A)-(B). This reimbursement "exception" to the anti-lien provision is therefore "limited to payments for medical care." 547 U.S. at 284-285. As a result, when a Medicaid beneficiary pursues damages claims against a third party and obtains a settlement, the State is entitled to only that portion of the settlement that represents "payments for medical care."[1] *Id.* at 285.

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[1] In this respect, Medicaid differs from other federal programs under which an individual who receives insurance benefits must reimburse the program or plan if she receives payment from a third party that is responsible to pay for the same injury. In those programs, the controlling statutory language provides that the amount of the reimbursement generally does not depend on how the proceeds of the third-party settlement are allocated among categories of damages. See 42 U.S.C. 1395y(b)(2)(B)(ii) (Medicare secondary-payer provisions state that beneficiary "shall reimburse" Medicare "for any payment made by the Secretary"); *Hadden* v. *United States*, 661 F.3d 298, 303-304 (6th Cir. 2011) (upholding right to full reimbursement and distinguishing Medicaid's statutory language), cert. denied, 133 S. Ct. 106 (2012); 33 U.S.C. 933(e)-(f) (Longshore and Harbor Workers' Compensation Act (LHWCA) permits reimbursement of full compensation payment unless doing so would result in net loss for employee); *Bloomer* v. *Liberty Mut. Ins. Co.*, 445 U.S. 74, 75 (1980) (LHWCA gives employer a lien against third-party recovery "in the amount of the compensation" paid by the employer); 5 U.S.C. 8132 (Federal Employees' Compensation Act (FECA) provides that beneficiary must reimburse "the amount of compensation paid by the United States" but may retain one-fifth of the net amount); *United States* v. *Lorenzetti*, 467 U.S. 167, 173-174 (1984) (government is entitled to recover from portions of settlement that represent damages not covered by FECA); *Sereboff* v. *Mid Atl. Med. Servs., Inc.*, 547 U.S. 356, 361 (2006) (in ERISA context, reimbursement rights are governed by plan terms, and fiduciary may enforce reimbursement provision by filing suit for "appropriate equitable relief" under 29 U.S.C. 1132(a)(3)). A suit by an ERISA plan for reimbursement is at issue in *U.S. Airways, Inc.* v. *McCutchen*, No. 11-1285 (argued Nov. 27, 2012).

The operation of the anti-lien provision in *Ahlborn* was straightforward. The State and the beneficiary had stipulated to the portion of the settlement—approximately $35,000—that represented payment for medical expenses. 547 U.S. at 280-281. With the proper apportionment thus determined, the anti-lien provision prohibited the State from seeking to recover more than the medical-payments portion of the settlement. *Id.* at 285. In light of the parties' agreement, the Court had no need to address the methods a State might permissibly use to determine a proper allocation in the first place. *Id.* at 288. The Court did state, however, that States have some discretion to craft "special rules and procedures for allocating tort settlements." *Id.* at 288 n.18.

2. Allocation rules govern a determination that is antecedent to the operation of the anti-lien provision: how to divide a settlement into a medical portion (recoverable) and a nonmedical portion (unrecoverable because it is the beneficiary's property). That assessment must be made because plaintiffs who bring tort suits generally assert claims for multiple types of damages—for instance, past and future medical care, lost wages, and pain and suffering. See, *e.g.*, *Ahlborn*, 547 U.S. at 273. A settlement compromises all of the plaintiff's claims and therefore represents compensation for multiple categories of damages. The settlement amount may reflect myriad case-specific considerations, including the parties' assessment of the likelihood the defendant will be found liable, the total amount the plaintiff claims, and the likelihood of actual recovery should the defendant be held liable. And the portion of the settlement that may appropriately be attributed to medical expenses may vary from case to case based on individual circumstances: for instance, the prospect that past medical expens-

es may be more definite in amount when compared to other items of damages; the medical expenses' value relative to other categories of damages; and the relative likelihood of recovering each type of damages. See *Price* v. *Wolford*, 608 F.3d 698, 707-708 (10th Cir. 2010).

3. Although the Medicaid Act does not require States to adopt a particular allocation method, see *Ahlborn*, 547 U.S. at 288, any method chosen must be consistent with the anti-lien provision. That is because allocation rules, by ascertaining the extent of the beneficiary's property, determine how—and whether—the anti-lien provision will limit the State's recovery against the settlement. States therefore may not use allocation rules in ways that circumvent the operation of the anti-lien provision.

In *Ahlborn*, the Court recognized that a State's methods of determining what constitutes the beneficiary's property, though technically antecedent to the anti-lien provision's prohibition on attaching that property, may have the impermissible effect of "circumvent[ing] the restrictions of the federal anti-lien statute." 547 U.S. at 286 n.16 (quoting Eighth Circuit's opinion below); see *Ahlborn* v. *Arkansas Dep't of Human Servs.*, 397 F.3d 620, 624 (8th Cir. 2005) (*Arkansas*). The Court explained that there was some question whether a State could "force a recipient to assign a chose in action to receive as much of the settlement as is necessary to pay Medicaid's costs" before "the applicant liquidates the property to a sum certain." *Ahlborn*, 547 U.S. at 286 n.16. By ensuring that the ultimate recovery—including payments for damages other than medical costs—would never become the beneficiary's property, such a requirement could have the effect of evading the anti-lien provision's limitation. *Arkansas*, 397 F.3d at 624; *Ahlborn*, 547 U.S. at 286 n.16. Although the

Court did not definitively resolve the question, it expressed doubt that such a statutory property rule for the Medicaid program would be consistent with the anti-lien provision, as that rule would equate to requiring assignment of the "right to compensation for lost wages and other nonmedical damages." 547 U.S. at 286 n.16; see *Martin* v. *City of Rochester*, 642 N.W.2d 1, 18 (Minn. 2002) (state statute requiring assignment of "all proceeds" from liable third parties could "allow[] the state to take by an assignment what is protected by the anti-lien provision," thereby "circumvent[ing]" that provision), cert. denied, 539 U.S. 957 (2003).

Like such an assignment rule, allocation rules may have the effect of circumventing the anti-lien provision. Although *Ahlborn* made clear that States have discretion to choose their methods of allocation, it also recognized that the method may have impermissible substantive effects on the parties' respective interests. 547 U.S. at 288. For instance, a beneficiary might seek to "allocate away the State's interest," *i.e.*, use settlement allocation to prevent the State from obtaining an attachable interest in any portion of the settlement. *Ibid.* The converse is also possible: a State could use an allocation rule to "allocate away" the beneficiary's interest in the settlement, for instance, by "allocating" 100% of the settlement to medical costs. See *Tristani* v. *Richman*, 652 F.3d 360, 378 (3d Cir. 2011). An allocation method that frustrates the operation of the anti-lien provision in this manner is preempted.[2] See *Davidowitz*, 312 U.S. at 67.

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[2] Amicus State of Texas asserts that legislation enacted pursuant to Congress's spending power cannot preempt state law. See State of Texas et al. Amicus Br. 18-23. That argument was not made below; it is not urged by petitioner; and it is foreclosed by this Court's prece-

B. North Carolina's Irrebuttable Presumption That Medical Costs Constitute Up To One-Third Of All Settlements Impedes The Operation Of The Anti-Lien Provision

North Carolina's across-the-board rule that the medical-costs portion of a settlement shall be deemed to be the lesser of the amount the State paid or one-third of the gross settlement amount, N.C. Gen. Stat. § 108A-57, frustrates the operation of the anti-lien provision. It is therefore preempted to the extent it forecloses the beneficiary from showing that Section 108A-57's allocation was inappropriate in her particular case.

1. Section 108A-57 establishes an irrebuttable "reimbursement lien" of the amount paid by the State or one-third of the settlement in all cases.[3] *Andrews* v.

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dent. As an initial matter, Texas's argument (Br. 20-21) that a State does not violate federal law by refusing to comply with conditions imposed by the Medicaid Act ignores *Ahlborn*, which held that the State's attempt to recover nonmedical damages "violates federal law." 547 U.S. at 286. Moreover, this Court has recognized that although Spending Clause statutes are in the nature of a contract, neither the federal statute itself nor the resulting arrangement with a fund recipient constitutes an ordinary contract. See *Bennett* v. *Kentucky Dep't of Educ.*, 470 U.S. 656, 669 (1985). The federal statute is binding law and can have preemptive effect under the Supremacy Clause. See, *e.g.*, *Dalton* v. *Little Rock Family Planning Servs.*, 516 U.S. 474, 476 (1996) (per curiam) ("In a pre-emption case such as this, state law is displaced" as inconsistent with the Medicaid statute "to the extent that it actually conflicts with federal law."); *Townsend* v. *Swank*, 404 U.S. 282, 283-285 (1971); *Carleson* v. *Remillard*, 406 U.S. 598, 603-604 (1972); *Blum* v. *Bacon*, 457 U.S. 132, 145-146 (1982); *Bennett* v. *Arkansas*, 485 U.S. 395, 397 (1988) (per curiam).

[3] Contrary to the argument advanced by the National Governors Association (Amicus Br. 14), the North Carolina Supreme Court did not construe Section 108A-57 as merely a "default," rebuttable rule. Although the *Andrews* court observed that "plaintiffs are free to negotiate a settlement with the State for a lien amount less than that

Haygood, 669 S.E.2d 310, 313 (N.C. 2008), cert. denied, 557 U.S. 904 (2009). The statute thus disregards the fact that the portion of each settlement that may appropriately be regarded as payment for past medical costs, and the portion that appropriately represents compensation for other damages and thus is the beneficiary's "property," vary in each case. See pp. 13-14, *supra*. Section 108A-57's "up to one-third" rule will inevitably overestimate the portion of the settlement that appropriately represents payment for past medical expenses in some cases, thereby "allocating away" the beneficiary's property.[4] See *Ahlborn*, 547 U.S. at 288. Indeed, Section 108A-57 has had precisely that effect in several North Carolina cases. See pp. 18-19, *infra*.

Petitioner therefore may not rely on the "allocation" label to defeat the contention that Section 108A-57 frustrates the anti-lien provision. Cf. *National Meat Ass'n* v. *Harris*, 132 S. Ct. 965, 973 (2012) (State could not avoid federal preemption concerning slaughter of live-

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required by our statutes," 669 S.E.2d at 313, the court was simply pointing out that the State can choose to waive its statutory entitlement in individual cases. The court recognized, however, that Section 108A-57 entitles the State to avoid "case-by-case determination of the medical expense portion of settlements." *Id.* at 314. Consistent with that interpretation, petitioner asserts here that the State is entitled to recover one-third of the settlement, regardless of respondents' disagreement with that allocation and regardless of the circumstances of this case. *E.g.*, Pet. Br. 24.

[4] For instance, the settlement may reflect the fact that the beneficiary-plaintiff sought only medical costs and lost wages; both damages claims involve concrete, calculable loss amounts; and the medical costs represent only one-tenth of the total amount claimed. Or the settlement might reflect the likelihood that the defendant third party would not be found liable for most or all of the medical costs paid by Medicaid—if, for instance, the defendant were found not to have proximately caused the need for aspects of the medical treatment.

stock by "framing" its statute as regulating the sale of meat slaughtered in a certain way). Section 108A-57 does not function as just one step in determining the appropriate extent of the parties' interests in individual cases. Rather, it imposes the State's unilateral judgment as to the amount to which the State is entitled. Substituting that unyielding presumption in all cases for consideration of individual circumstances ensures that the State will sometimes allocate nonmedical damages to itself—while denying beneficiaries the protection of the anti-lien provision on the basis of the prescribed allocation. Such avoidance effectively circumvents the anti-lien provision. *Martin*, 642 N.W.2d at 18 (assignment statute that "circumvents the anti-lien provision and eliminates the efficacy of that provision's protection" is preempted).

The conclusion that Section 108A-57 enables circumvention of—and thus conflicts with—the anti-lien provision is reinforced by the fact that the State previously construed the statute to authorize recovery of portions of a settlement allocated to nonmedical damages. Section 108A-57 has been in effect in materially similar form since before this Court decided *Ahlborn*. See, *e.g.*, N.C. Gen. Stat. § 108A-57 (1997). Before *Ahlborn*, the State asserted, and the North Carolina courts agreed, that Section 108A-57 entitled the State "to recover the costs of medical treatment provided * * * , even when the funds received by the [beneficiary] are not reimbursement for medical expenses." *Campbell* v. *North Carolina Dep't of Human Res.*, 569 S.E.2d 670, 672 (N.C. Ct. App. 2002) (upholding reimbursement even though "the settlement money which plaintiff received was not recompense for medical expenses"); see also *Ezell* v. *Grace Hosp., Inc.*, 631 S.E.2d 131 (N.C. 2006)

(reversing lower-court judgment against State for reasons stated by the dissenting judge below, who relied on *Campbell*); *Payne* v. *State, Dep't of Human Res.*, 486 S.E.2d 469, 471 (N.C. Ct. App. 1997) (upholding State's right to recover damages allocated to a special-needs trust).

Ahlborn, of course, established that Section 108A-57, as so construed, violated the anti-lien provision. In response, the State did not change the provision. Instead, it recharacterized the statute, contending that Section 108A-57 merely prescribes an allocation method. Thus, the State argued that "a North Carolina Medicaid recipient's medical damages are apportioned by statute: up to one-third of the settlement is for medical damages." New Br. for Intervenor-Appellee at *14, *Andrews*, *supra* (No. 57A07-2) (2008 WL 2791330). The North Carolina Supreme Court agreed with that new characterization and upheld the statute as an allocation method permitted by *Ahlborn*. See *Andrews*, 669 S.E.2d at 313-314.

This history demonstrates that despite the current characterization as an "allocation" method, see Pet. Br. 24, North Carolina's irrebuttable presumption has essentially the same effect in some cases as the Arkansas statute at issue in *Ahlborn*: it permits the State to recover portions of a settlement that "are not reimbursement for medical expenses." *Campbell*, 569 S.E.2d at 672. The pre-*Ahlborn* cases in which the State was permitted to recover payments that represented nonmedical damages would come out the same way today. Only the reasoning would be different: now those same nonmedical damages would be irrebuttably "allocated" to past medical expenses. The State may not resort to such formalism to defeat the anti-lien provision. Cf.

National Meat Ass'n, 132 S. Ct. at 973; *AT&T Mobility LLC* v. *Concepcion*, 131 S. Ct. 1740, 1747-1748 (2011) (State may not evade preemptive effect of Federal Arbitration Act by characterizing rule that effectively prevented class arbitration as a contract-law rule of general applicability).

2. Petitioner's arguments that North Carolina's statutory framework is not preempted by the anti-lien provision are not persuasive.

a. Petitioner first contends (Br. 20-23) that Section 108A-57 sets forth a state tort-law rule for apportioning damages to which the Medicaid Act does not speak. As petitioner correctly observes, state tort law determines a personal-injury plaintiff's substantive entitlement to damages in the first instance, such as by capping the amount that can be awarded by a jury. Pet. Br. 22. State law also furnishes the procedural rules that govern tort actions, such as defenses or statutes of limitations. *Id.* at 21. Such rules of general application are unlikely to conflict with the anti-lien provision's requirement that whatever damages a plaintiff receives under those rules, the State may not recover more than the amount that appropriately represents payment for medical costs.

Section 108A-57, however, does not govern the damages a plaintiff may receive for particular claims or the procedures applicable in tort actions, either in general or in the Medicaid context in particular. It does not, for example, limit a plaintiff's substantive right to recover certain types of damages or limit the jury's or the parties' discretion to calculate damages in any way. See Pet. Br. 25 (plaintiff retains "full discretion" to compromise claims). Nor is Section 108A-57 in terms limited to recoveries resulting from state-law claims: it presuma-

bly permits the State to recover damages awarded pursuant to federal statutes, such as the Jones Act, 41 Stat. 988, and the Federal Employers' Liability Act, 45 U.S.C. 51 *et seq.* Rather than establishing the extent of a plaintiff's rights under general state tort law, then, Section 108A-57 directly governs the State's and the beneficiary's respective rights when the beneficiary has received Medicaid payments for which a third party may be liable. Thus, Section 108A-57 must be consistent with the anti-lien provision.

The fact that North Carolina has a similar medical-lien rule of general applicability that governs when a personal-injury plaintiff is "indebted" to medical providers, N.C. Gen. Stat. §§ 44-49, 44-50 (2011), does not require a different conclusion. That statute does not apply to Medicaid beneficiaries, who are not indebted to providers for their care. See 42 C.F.R. 447.15. To be sure, in the situations in which it does apply, Section 44-50 operates much like Section 108A-57, establishing a lien on 50% of the net recovery, regardless of the nature and apportionment of the damages awarded. The existence of that rule demonstrates that Section 108A-57's irrebuttable statutory lien and its reliance on a "one-third gross" rule of thumb are not unique in North Carolina law. But that does not change the fact that in the Medicaid context, the State may not decree the portion to which it is entitled without affording the beneficiary some opportunity to challenge that assertion.

b. Petitioner also contends (Br. 24) that Section 108A-57 is consistent with the anti-lien provision, as interpreted in *Ahlborn*, because *Ahlborn* indicated that States may mitigate concerns about manipulation of settlements by requiring "the State's advance agreement to an allocation." 547 U.S. at 288. Section 108A-

57, petitioner argues, may be characterized as "an advance agreement that the State will reduce its lien" to one-third of the settlement if medical costs exceed that portion of the gross settlement. Br. 24. But without any mechanism for an individualized determination when the State and the beneficiary cannot agree about the proper allocation in a particular case, the State's "agreement" is simply a unilateral decree.

Petitioner also argues (Br. 24) that Section 108A-57 prospectively instructs parties concerning the amount of their settlements that they must allocate to past medical costs. If that characterization alone were sufficient to save Section 108A-57 from preemption, however, a State could prospectively require the parties to allocate 90% or 100% to medical costs. See *Tristani*, 652 F.3d at 378; Pet. App. 53a; see also *Ahlborn*, 547 U.S. at 288 ("A rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others."). As *Ahlborn* suggested, moreover, States may not circumvent the anti-lien provision by imposing front-end rules that effectively require the beneficiary to give up her property before she obtains it. See *id.* at 286 n.16.

3. In addition to his arguments regarding the proper characterization of Section 108A-57, petitioner asserts (Br. 33-36) that CMS has concluded that Section 108A-57 is a permissible means of allocating settlements.

a. Petitioner first relies (Br. 34-35) on a 2006 CMS Guidance Memo regarding "State Options for Recovery Against Liability Settlements In Light of U.S. Supreme Court Decision in [*Ahlborn*]." See Pet. App. 124a-138a. That reliance is misplaced.

The Guidance Memo, issued to explain *Ahlborn*'s impact and suggest permissible methods of recovery in light of the decision, emphasizes that *Ahlborn* held that

States "may only recover from the amount of a [settlement] that is allocated to healthcare (medical) items and services." Pet. App. 129a. In the passage on which petitioner relies, the Guidance Memo states that "State tort or insurance liability provisions are a matter of State law and could be utilized to mitigate the adverse [e]ffects of the decision," and that "[f]or example, a State can enact laws which provide for a specific allocation amongst damage[s], i.e., pain and suffering, lost wages, and medical claims." *Ibid.*

Petitioner contends (Br. 35) that Section 108A-57 is among the methods contemplated by the Guidance Memo because it "provid[es] for a specific allocation amongst damage[s]." But petitioner reads that language in isolation from the rest of the Guidance Memo. CMS expressly cautioned that in *Ahlborn*, this Court had rejected CMS's interpretation of the Medicaid Act to permit full recovery of assistance payments "regardless of how the parties allocated the settlement." Pet. App. 127a. CMS further explained that *Ahlborn* held that "to the extent State laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws." *Ibid.* CMS thus made clear that it read *Ahlborn* to prohibit States from unilaterally disregarding an appropriate allocation of damages—which is effectively what statutes like Section 108A-57 do.

In context, then, the paragraph on which petitioner relies is best read as making two points. First, the reference to a State's substantive use of "State tort * * * provisions" could include such things as instituting generally applicable caps on the nonmedical damages that a plaintiff may recover. Pet. App. 129a. Second, States

may enact "laws which provide for a specific allocation amongst damage[s]"—*i.e.*, procedures providing for determining the proper allocation among damages within a settlement. *Ibid.* The Guidance Memo does not say that a State may employ statutes that determine the extent of the State's recovery without any opportunity for the beneficiary to demonstrate the amount that is "appropriately designated as payment for medical items and services."[5] *Id.* at 127a.

b. Petitioner also relies (Br. 34) on a 2009 letter from the Acting Associate Regional Administrator of CMS's Division of Medicaid & Children's Health Operations (Atlanta), replying to an inquiry from Representative Howard Coble of North Carolina. See Pet. App. 139a-142a. Representative Coble referred to a letter from David Andrews, a plaintiff in the *Andrews* case, in which Mr. Andrews argued that Section 108A-57 was inconsistent with the 2006 CMS Guidance Memo. *Id.* at 139a. CMS's response, which was not copied to the State's Department of Health and Human Services, stated that CMS "agree[d]" with the North Carolina Supreme Court's conclusion in *Andrews* and that Section 108A-57 was a "reasonable statutory scheme for apportioning medical expenses" that did not "conflict with CMS' guidance." *Id.* at 141a-142a.

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[5] In addition, the Guidance Memo's statement that "a State could enact laws which give priority to the repayment of medical expenses," Pet. App. 130a, indicates that a State may provide that it has the right to recover from the portion of a judgment or settlement appropriately allocated to medical costs even if that means that the remainder of the judgment or settlement reflecting nonmedical costs is insufficient to provide full or proportional payment of those other claims. See pp. 30-31, *infra*.

The CMS Administrator, in consultation with the Secretary, has concluded that the response to Representative Coble was incorrect. The Secretary's interpretation of the relevant provisions of the Medicaid Act and the 2006 CMS Guidance Memo is reflected in this brief.

In any event, petitioner is wrong to suggest (Br. 34-36) that the 2009 letter had the force of law or that it represented a binding agency interpretation. As a general matter, CMS does not treat informal responses to such inquiries as binding regulatory actions. Indeed, the limited force of the letter is clear from its nature and the manner in which it was issued. It was not the culmination of any formal or informal administrative rulemaking or adjudicatory process to which the State or a private person was a party; rather, the correspondence was essentially a "workaday advice letter that [CMS] prepare[s] countless times per year" in response to what CMS informs this Office is a large volume of inquiries from the public and Members of Congress. See *Independent Equip. Dealers Ass'n* v. *EPA*, 372 F.3d 420, 427 (D.C. Cir. 2004) (Roberts, J.) (letter written in response to inquiry from regulated party was not final agency action because it "had no binding effect whatsoever—not on the agency and not on the regulated community"); cf. *Christensen* v. *Harris Cnty.*, 529 U.S. 576, 587 (2000) (opinion letters issued without formal process do not have the force of law); *United States* v. *Mead Corp.*, 533 U.S. 218, 233 (2001). And rather than reflecting an affirmative agency decision to provide guidance to those responsible for administering the Medicaid program, the letter was sent in response to an unsolicited inquiry

from a party other than the State.[6] See, *e.g.*, *Holk* v. *Snapple Beverage Corp.*, 575 F.3d 329, 342 n.6 (3d Cir. 2009); *Association of Am. R.R.s* v. *DOT*, 198 F.3d 944, 948 (D.C. Cir. 1999).

CMS does not use correspondence like the 2009 letter as a vehicle for issuing instructions to the States concerning their administration of the Medicaid program. When CMS wishes to issue formal guidance, it sends the guidance directly to the State in question, or issues State Medicaid Director Letters or Memoranda to Associate Regional Administrators for Medicaid and State Operations. See Centers for Medicare & Medicaid Services, Dep't of Health & Human Servs., *Federal Policy Guidance*, http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html (last visited Dec. 17, 2012). The 2006 Guidance Memo is an example of such formal guidance, and it contains CMS's official advice to the States concerning permissible methods of recovering medical costs after *Ahlborn*.

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[6] There is no indication that the State relied on the 2009 letter in formulating its construction of Section 108A-57 or its conclusions about what methods of recovering medical payments were permissible after *Ahlborn*. By the time the letter was sent, the State had already argued—successfully—in *Andrews* that Section 108A-57's irebuttable presumption was consistent with *Ahlborn* and the anti-lien provision. *Andrews*, 669 S.E.2d at 312-314.

II. STATES HAVE CONSIDERABLE DISCRETION TO ESTABLISH ALLOCATION PROCEDURES THAT BOTH PROTECT THE STATES' ABILITY TO RECOVER MEDICAL COSTS AND PERMIT AN INDIVIDUALIZED ALLOCATION DETERMINATION WHEN NECESSARY

Because the portion of a settlement that may appropriately be regarded as payment for medical costs may vary based on case-specific factors, state allocation methods must provide some opportunity for individualized consideration when necessary to avoid frustrating the operation of the anti-lien provision. Consistent with that constraint, States have broad discretion to adopt allocation procedures that protect the States' interest in reimbursement and ensure that allocation inquiries are efficient and equitable. The Medicaid Act requires States to "take all reasonable measures to ascertain the legal liability of third parties," 42 U.S.C. 1396a(a)(25)(A), and while allocation measures that circumvent the anti-lien provision are not "reasonable," States otherwise have considerable leeway to develop methods of allocating settlements.

As petitioner observes (Br. 31-32), States have substantial interests in guarding against settlement manipulation by Medicaid recipients and in preventing allocation determinations from consuming limited resources. See *Ahlborn*, 547 U.S. at 288. The federal government shares these interests, as it is entitled to a portion of a State's third-party recovery, see 42 U.S.C. 1396k(b), and States may seek reimbursement from CMS for a portion of their administrative expenses in litigating any allocation issues, see 42 C.F.R. 433.15(b)(7). *Ahlborn* suggested that States may "adopt[] special rules and procedures for allocating tort settlements * * * to meet concerns about settlement manipulation," 547 U.S. at

288 n.18, including by requiring the State's consent to an allocation or "submitting the matter to a court for decision," *id.* at 288. Many States have established such procedures, demonstrating that, despite petitioner's argument to the contrary (Br. 26-33), allocation procedures that provide for individualized determination when necessary can effectively prevent manipulation and promote efficiency.

A. States May Employ Hearings To Determine The Appropriate Allocation, Aided By Presumptive Allocation Rules And Other Procedural Protections

Although States have the authority to protect their reimbursement interests by intervening in third-party litigation and participating in settlement negotiations, see Part II.B, *infra*, they also have the discretion to stay out of the litigation and resolve allocation issues after the beneficiary and the third party have settled the beneficiary's claims. When States choose the latter course, they may use judicial or administrative allocation hearings to provide an opportunity when necessary to determine the appropriate allocation. See Pet. App. 47a-49a (discussing examples); *Ahlborn*, 547 U.S. at 288 n.18. They may also, of course, simply negotiate an appropriate allocation with the beneficiary.

Sixteen States and the District of Columbia explicitly provide the opportunity for a post-settlement judicial or administrative hearing to determine the appropriate apportionment of damages. Such hearings are either expressly provided for by statute or are provided in accordance with state-court decisions holding that allocation hearings are required.[7] Although petitioner con-

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[7] Cal. Welf. & Inst. Code § 14124.76(a) (West 2011); D.C. Code § 4-604(b) (2011); Haw. Rev. Stat. Ann. § 346-37(h)-(i) (LexisNexis

tends (Br. 28-29) that such hearings are unworkable inquiries that place the State "at a decided disadvantage" because of the beneficiary's superior knowledge of the underlying litigation and settlement, Br. 28, some States that have adopted allocation hearings have also instituted procedural protections that address petitioner's concerns.

For instance, five States have established *rebuttable* presumptions that all or a specified percentage of settlement proceeds is appropriately allocated to payment of medical expenses.[8] Those presumptions tend to counter the State's relative lack of familiarity with the underlying litigation and settlement by requiring the beneficiary to justify a deviation from the presumptive allo-

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Supp. 2012); 305 Ill. Comp. Stat. Ann. 5/11-22 (West 2008); Mass. Ann. Laws ch. 118E, § 22(c)-(d) (LexisNexis Supp. 2012); Miss. Code Ann. § 43-13-125(2) (West 2008); Mo. Ann. Stat. § 208.215.9 (West 2010); N.H. Rev. Stat. Ann. § 167:14-a(IV) (LexisNexis 2010); Okla. Stat. Ann. Tit. 63, § 5051.1(D)(1)(d) (West Supp. 2013); 62 Pa. Cons. Stat. Ann. § 1409.1(b) (West 2010); Tenn. Code Ann. § 71-5-117(g)-(j) (2012); Va. Code Ann. § 8.01-66.9 (Supp. 2012); *State Dep't of Health & Welfare* v. *Hudelson*, 196 P.3d 905, 910 (Idaho 2008); *Smith* v. *Alabama Medicaid Agency*, 461 So. 2d 817, 820 (Ala. Civ. App. 1984); *Martin*, 642 N.W.2d at 27 (remanding for allocation hearing) (Minn. statute); *Lugo* v. *Beth Israel Med. Ctr.*, 819 N.Y.S.2d 892 (N.Y. Sup. Ct. 2006); *In re E.B.*, 729 S.E.2d 270 (W. Va. 2012). Other States may employ administrative procedures of general application or may litigate allocation as part of the underlying tort action, even though their third-party reimbursement statutes do not explicitly so provide.

[8] See Haw. Rev. Stat. Ann. § 346-37(h) (one-third allocation); *Hudelson*, 196 P.3d at 911-912 (construing Idaho Code Ann. § 56-209b(6) (1961) to establish a presumption of full reimbursement); Mass. Ann. Laws ch. 118E, § 22(b)-(c) (full reimbursement); Okla. Stat. Ann. Tit. 63, § 5051.1(D)(1)(d) (full reimbursement); 62 Pa. Cons. Stat. Ann. § 1409(b)(11) (West 2010) (one-half of settlement after fees are deducted).

cation. To the extent that North Carolina tort law reflects, as petitioner argues, a "rule of thumb" that one-third of a settlement generally should be allocated to past medical expenses, Pet. Br. 22-23, the State would be free to establish a rebuttable presumption reflecting that principle, or to construe Section 108A-57 to so provide. A rebuttable-presumption framework affords beneficiaries an opportunity to establish that the presumptive allocation does not represent an appropriate allocation in a given case.

States may also protect against manipulation and the possibility that decisionmakers will reflexively favor beneficiaries by setting forth relevant criteria to consider when adjudicating the proper allocation. Some States have adopted a method known as proportional reduction, in which the amount of the State's recovery is reduced by the proportion of the total settlement amount to the reasonable value of the beneficiary's claims.[9] As the court of appeals recognized, however, Pet. App. 49a-50a, States are free to adopt other methods. Thus, although the State and the beneficiary in *Ahlborn* stipulated that the State's lien amount should be proportionately reduced if the State's bid for full reimbursement was rejected, 547 U.S. at 274, this Court did not suggest that a proportional-reduction approach is necessarily required, see *id.* at 288 n.18; see also Pet. App. 50a; *Smalley* v. *Nebraska Dep't of Health & Human Servs.*, 811 N.W.2d 246, 257 & n.34 (Neb. 2012) (holding that proportional reduction is not required and citing cases), pet. for cert. pending, No. 12-466 (filed Oct. 11, 2012).

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[9] See, *e.g.*, Mo. Ann. Stat. § 208.215.11; *Lima* v. *Vous*, 94 Cal. Rptr. 3d 183, 197 (Cal. Ct. App. 2009) (approving proportional reduction as one method).

As petitioner explains (Br. 31-32), proportional reduction may disadvantage the State if it ignores the fact that past medical costs are often much more concrete, definite, and recoverable than other possible elements of damages, such as pain and suffering. See *McKinney* v. *Philadelphia Hous. Auth.*, No. 07-4432, 2010 WL 3364400, at *7 (E.D. Pa. Aug. 24, 2010). Similarly, proportional reduction based on a plaintiff's claimed damages would enable the beneficiary to reduce the State's recovery by inflating the amount of intangible damages sought. States accordingly may set forth other specific factors that the decisionmaker should take into account, or provide general guidance that the allocation should be equitable to both sides.[10]

States may also prevent collusive agreements to "allocate away the State's interest," *Ahlborn*, 547 U.S. at 288, by providing that any allocation made by the beneficiary and third parties or a court is not final absent the State's consent or a hearing to determine the appropriate allocation. See Resp. Br. 31-32. Several States have adopted such provisions.[11] In this respect, the hearing process can serve as a settlement-approval mechanism that evaluates the parties' tentative allocation, while also protecting the State's interest in appropriate reimbursement.

States may also institute procedural protections within allocation hearings to ensure a level playing field.

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[10] See, *e.g.*, Cal. Welf. & Inst. Code § 14124.76(a); Mo Ann. Stat. § 208.215.11; N.H. Rev. Stat. Ann. § 167:14-a(IV); Tenn. Code Ann. § 71-5-117(g)-(h); Va. Code Ann. § 8.01-66.9; *Moss* v. *Glynn*, 383 N.E.2d 275 (Ill. Ct. App. 1978) (discussing considerations, including prevention of double recovery).

[11] See, *e.g.*, Hawaii Rev. Stat. Ann. § 346-37(h); Mass. Ann. Laws ch. 118E, § 22(d); 55 Pa. Code § 259.2(b)(5) (2012).

For instance, requiring disclosure to the State of pertinent information regarding the incident, injuries, claims, and settlement that the other parties possess (pursuant to a protective order if appropriate) can ensure that the State is able to "meaningfully participate" in the hearing. Although the State even then might not be on an equal footing with the beneficiary and the tortfeasor or its insurer, see Pet. Br. 15, requiring that the State be afforded access to material evidence and other information can at least mitigate the disadvantage.

Finally, it is important to keep in mind that whatever procedure or rebuttable presumption a State's third-party reimbursement framework establishes, hearings may only rarely be necessary. Instituting rebuttable presumptions or other rules governing allocation will tend to encourage settlement by clarifying the parties' respective rights and focusing negotiations. Thus, once the particular State's ground rules are known, it may usually be possible for the state Medicaid agency and the beneficiary to agree to an allocation and avoid the need for an allocation hearing. Indeed, many States' statutes expressly contemplate settlement of the State's lien.[12]

B. States May Also Participate In Third-Party Litigation

As *Ahlborn* recognized, States may also protect their interest in reimbursement by conducting, or participating in, third-party litigation *before* any settlement is finalized. 547 U.S. at 288. The Medicaid Act instructs States to require that a Medicaid beneficiary cooperate

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[12] See, *e.g.*, Ariz. Rev. Stat. Ann. § 36-2915(H)-(I) (West 2009); Me. Rev. Stat. Ann. Tit. 22, § 14 (West Supp. 2012); Md. Code Ann., Health-Gen. § 15-120(c)(3) (LexisNexis 2009); S.C. Code Ann. § 43-7-440 (West Supp. 2011).

with the State's attempt to secure third-party recovery, 42 U.S.C. 1396k(a)(1)(C), and States may impose a range of procedural protections to ensure cooperation.

States may protect their right to participate in third-party litigation or settlement negotiations by permitting or requiring their joinder or intervention. See Pet. App. 130a. For instance, under North Carolina law, petitioner could have intervened in respondents' suit, but he chose not to attempt to do so until after the parties had entered into a settlement. *Id.* at 7a n.1. States may also choose to participate only at the settlement stage, and to that end they may require advance notice of settlement negotiations. See *id.* at 130a. Some States also require the parties to obtain the State's advance consent to an allocation and provide for a hearing if no agreement is possible.[13]

State participation in third-party litigation has the advantage of avoiding the need to resolve *post hoc* questions about the settlement that the parties reached and preventing any manipulation by the parties. Although States may not have the resources to intervene in every third-party suit or settlement negotiation, they may provide themselves with broad discretion to participate when they so choose, while also adopting procedures for individualized post-settlement allocation determinations in the cases in which they do not participate.

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[13] See Cal. Welf. & Inst. Code § 14124.76(a); Miss. Code Ann. § 43-13-125(1), (2); Tenn. Code Ann. § 71-5-117(g)-(j).

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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No. 12-98

In the Supreme Court of the United States

ALBERT A. DELIA, ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner

v.

E.M.A. (BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON), WILLIAM EARL ARMSTRONG AND SANDRA ARMSTRONG,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF AMICI CURIAE OF AARP AND CONSTITUTIONAL ACCOUNTABILITY CENTER IN SUPPORT OF RESPONDENTS URGING AFFIRMANCE

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INTERESTS OF *AMICI CURIAE*[1]

AARP is a non-partisan, non-profit membership organization for people 50 and over. AARP advocates for health and economic security for everyone and in particular for vulnerable people of all ages, including low-income people and persons with disabilities. AARP supports access to and expansion of quality health care through publicly administered health insurance programs, including Medicaid, an essential safety net program that provides coverage to people who would otherwise be denied health care. To further that end, Medicaid recipients' access to the courts to challenge adverse actions by Medicaid is critical.

Constitutional Accountability Center (CAC) is a think tank, public interest law firm, and action center dedicated to fulfilling the progressive promise of our Constitution's text and history. CAC works in our courts, through our government, and with legal scholars to improve understanding of the Constitution and to preserve the rights and freedoms it guarantees. CAC has a strong interest in constitutional federalism and in preserving the federal powers granted by the Constitution. Accordingly, CAC has an interest in the interaction

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[1] The parties' letters of consent to the filing of this brief have been filed with the Clerk. Under Rule 37.6 of the Rules of this Court, *amici* state no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amici curiae* or their counsel made a monetary contribution to its preparation or submission.

between the Supremacy Clause and the Spending Clause raised in this case. CAC has filed numerous *amicus curiae* briefs in this Court in cases raising significant issues regarding the text and history of the original Constitution and the Bill of Rights, including *Clapper v. Amnesty, International USA*, No. 11-1025; *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 132 S. Ct. 2566 (2012); *McDonald v. City of Chi.*, 130 S. Ct. 3020 (2010); and *Padilla v. Kentucky*, 130 S. Ct. 1473 (2010).

INTRODUCTION AND SUMMARY OF ARGUMENT

The *amici curiae* brief of Texas, *et al.*, urges this Court to apply "federalism-protecting interpretive canons" to reach the conclusion that the federal Medicaid statute is "incapable of 'preempting' state law." Texas Br. 1, 18. Texas contends that Medicaid is "spending legislation" that "does not obligate the States to do *anything*." *Id.* at 20 (emphasis in original). This argument was neither presented below nor raised in the Petition for Certiorari. But if the Court decides to entertain *amici*'s argument, it should reject their contention. Texas's position is contrary to the text and history of our Constitution, more than 200 years of precedent upholding the supremacy of federal law, and the clear language of the Medicaid statute.

The drafters of our Constitution were acutely aware of the dysfunction of the Articles of Confederation, which established a loose confederacy built merely on a "firm league of friendship" among

thirteen independent states. ARTICLES OF CONFEDERATION of 1781, art. III. The "business" of the Constitutional Convention was to correct the "vices" resulting from the lack of "effectual controul in the whole over its parts." 1 RECORDS OF THE FEDERAL CONVENTION OF 1787, at 167 (Max Farrand ed., 1911) [hereinafter RECORDS] (statement of James Wilson of Pennsylvania). The Framers viewed a government lacking a supreme federal power as "a monster, in which the head was under the direction of the members." THE FEDERALIST NO. 44 (James Madison).

The delegates considered assigning the task of enforcing the supremacy of federal law to the military and Congress. If that had been the constitutional text, then private parties would have had no role in the invalidation of state statutes that conflict with federal law. But the Founders instead chose to rely upon judicial review of cases brought by injured parties, including private individuals. The Framers wrote into the Supremacy Clause a mandate for the judicial branch to void "any Thing" in state law to the "Contrary" of federal law. U.S. CONST. art. VI, § 2. The Founders did not assign the executive or legislative branches an exclusive role in bringing litigation to uphold federal law. To the contrary, the text of the Supremacy Clause is broadly worded to confer a right to relief upon the people, as well.

There is no reason in the Constitution's text or history to exclude federal law enacted pursuant to Congress's powers under the Spending Clause from the standard preemption jurisprudence of the

Supremacy Clause. Indeed, the history of the Spending Clause shows that the Framers intended to grant power to the federal government to displace state law when the national interest required. The focus of the Founding generation on the need for federal power to supplant inadequate or parochial state laws demonstrates that Spending Clause legislation was clearly intended to have preemptive effect.

For more than 200 years, the judicial branch has permitted suits, including those brought by private parties, to challenge state laws that allegedly violate federal law and requirements. As Chief Justice John Marshall explained, the Framers expected that some state laws would conflict with federal statutes and in "every such case" the law of the state "must yield" to federal law. *Gibbons v. Ogden*, 22 U.S. 1, 211 (1824).

It is imperative for constitutional federalism that the Supremacy Clause be applied properly; as Justice Kennedy has observed, "the whole jurisprudence of preemption" is of vital importance to "maintaining the federal balance." *United States v. Lopez*, 514 U.S. 549, 578 (1995) (Kennedy, J., concurring).

This Court has upheld the preemptive effect of Spending Clause statutes, including Medicaid, in numerous cases. *See, e.g., Ark. Dept. of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 292 (2006). The contention of Texas that the Medicaid Act as a whole has no preemptive effect is contrary to this

Court's determination that states accepting federal Medicaid funds must comply with the mandatory terms of the statute. *See, e.g.*, *Frew v. Hawkins*, 540 U.S. 431, 433 (2004). The Medicaid provisions at issue in this case are, indeed, mandatory, and impose binding obligations on the States. While some of the applicable provisions are contained within a list of State plan requirements, Congress has specified that State plan requirements are privately enforceable. 42 U.S.C. §§ 1320a-2, 1320a-10 (2006).

Texas's argument that the preemptive force of the Medicaid statute is eliminated by the power of the federal government to withhold funds is baseless. Nothing in the text of the Medicaid statute, including the provision authorizing federal sanctions for failure to comply, 42 U.S.C. § 1396c, alters the compulsory nature of Medicaid requirements. This Court has repeatedly permitted private enforcement of Medicaid, ignoring or rejecting arguments that the reduction of federal funding is the exclusive remedy. *See, e.g.*, *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644 (2003) [hereinafter *PhRMA v. Walsh*]; *Blessing v. Freestone*, 520 U.S. 329, 348 (1997).

ARGUMENT

I. The Text and History of the Supremacy Clause and Spending Clause Establish the Preemptive Effect of Mandatory Medicaid Provisions

The Framers wrote the Supremacy Clause to ensure that properly enacted federal law displaces

conflicting state law. The Founders granted specific law-making powers to the federal government in the Constitution, in order to allow Congress to legislate for the country as a whole whenever a national solution is necessary or preferable. The Spending Clause is an integral part of the Founders' vision of federal power, and laws enacted pursuant to Congress's spending power clearly have preemptive force. Texas's assertion that mandatory provisions in the Medicaid statute do not preempt contrary state laws should be rejected, if considered at all.

A. The Framers Drafted the Supremacy Clause to Ensure Judicial Invalidation of All State Laws that Conflict with Federal Law, Permitting Enforcement of Federal Law by Private Parties

At the Constitutional Convention in 1787, James Wilson of Pennsylvania explained that "the business of this convention" is to correct the "vices" of the Articles of Confederation, including "the want of effectual controul in the whole over its parts." 1 RECORDS, at 167. The Framers viewed the failure of the Articles of Confederation to ensure the supremacy of federal law as a "fatal omission." JACK N. RAKOVE, ORIGINAL MEANINGS: POLITICS AND IDEAS IN THE MAKING OF THE CONSTITUTION 167 (1996). The Founding generation extensively debated different possible means for the invalidation of state laws in conflict with federal law. Ultimately, judicial review in suits that could be brought by private parties was

selected as the constitutional mechanism to void contrary state laws.

Governor Edmund Randolph of Virginia proposed an initial mechanism to ensure the supremacy of federal law, recommending that the "National Legislature" be given the power "to negative all laws passed by the several States," as well as the power "to call forth the force of the Union" against a state "failing to fulfill its duties." 1 RECORDS, at 21. While James Madison supported the legislative "negative," he strongly disagreed with reliance upon military force to resolve conflicts between federal and state law. He stated: "The use of force agst. a State, would look more like a declaration of war, than an infliction of punishment, and would probably be considered by the party attacked as a dissolution of all previous compacts by which it might be bound." *Id.* at 54. Randolph was persuaded to change his position, agreeing that the use of force would be "impracticable, expensive [and] cruel to individuals." *Id.* at 256 (emphasis omitted).

While Madison convinced his colleagues to relinquish the military option, he could not persuade them to embrace the use of congressional power to invalidate state laws. His reasoning in support of the congressional negation of state law met with fierce resistance, precisely because a majority of delegates preferred to rely on judicial review for this important task. 2 RECORDS, at 27-28. During the debate on the "congressional negative," Gouverneur Morris of New York and Roger Sherman of Connecticut insisted that the responsibility to invalidate conflicting state laws

was properly in the province of the judiciary. *Id.* The proposal for Congress to nullify state laws was defeated by a vote of three states in favor to seven states against. *Id.* at 28.

Immediately after the defeat of the "congressional negative," Luther Martin of Maryland proposed a constitutional clause stating "that the Legislative acts of the [United States] . . . shall be the supreme law of the respective States . . . [and] that the Judiciaries of the several States shall be bound thereby in their decisions, any thing in the respective laws of the individual States to the contrary notwithstanding." *Id.* at 28-29. Martin's proposal passed unanimously without debate. *Id.* at 29. John Rutledge of South Carolina recommended adding that the United States Constitution is supreme to state laws, a proposal that likewise passed without dissent. *Id.* at 389. The Committee on Detail changed the phrase "the Judiciaries of the several States" to "the judges in the several states." *Id.* at 183. As modified, the clause required both state and federal courts to uphold the supremacy of federal law.

Significantly, the Committee on Style Revision replaced the words "the supreme law of the states" with the phrase "the supreme law of the land." *Id.* at 603. Professor Amar explains that "the implication was continental: one Constitution, one land, one People." Akhil Reed Amar, *Of Sovereignty and Federalism*, 96 YALE L.J. 1425, 1458 (1987). The Founding generation believed that federal laws "would embody the judgment of America as a whole,

as distinct from the more parochial view of any particular local part," and therefore federal statutes have "priority over any inconsistent state-law norm." AKHIL REED AMAR, AMERICA'S CONSTITUTION: A BIOGRAPHY 300 (2005). The Supremacy Clause establishes federal law as embodying the will of the nation's people, who are empowered to turn to the judiciary for enforcement.

The words of the Supremacy Clause, as finalized, provide:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. CONST. art. VI, § 2. Thus, all constitutional federal laws are the supreme law of the land, with no exceptions envisioned in the text. The Supremacy Clause does not restrict enforcement of federal law to suits brought by Congress or the executive branch, allowing private individuals to invoke judicial review to invalidate conflicting state laws.

During ratification, the Framers devoted considerable attention to the importance of the Supremacy Clause as a justification for the people to

vote in favor of the Constitution. In the *Federalist Papers*, James Madison and Alexander Hamilton jointly wrote essays criticizing historical examples in which the national government had no means of enforcing its will over independent and sovereign states. THE FEDERALIST NOS. 18, 19, 20 (Alexander Hamilton & James Madison). They mocked governments lacking federal supremacy as prone to anarchy, imbecility, and discord. *Id.* They jointly concluded that a government established as "a sovereignty over sovereigns" is in practice "subversive of the order and ends of civil polity." THE FEDERALIST NO. 20 (Alexander Hamilton & James Madison). Writing separately, Hamilton asserted that if the "laws of the Union" are not "the SUPREME LAW of the land," then "they would amount to nothing." THE FEDERALIST NO. 33 (Alexander Hamilton). Madison similarly declared that without the Supremacy Clause, the Constitution "would have been evidently and radically defective." THE FEDERALIST NO. 44 (James Madison). He likened a government that did not enforce the supremacy of federal law to "a monster, in which the head was under the direction of the members." *Id.*

The Framers viewed the supremacy of federal law as a critically important facet of the new government. They explicitly rejected exclusive assignment of this task to the executive and legislative branches. Instead, they opened the courthouse doors to suits by private parties, as well as governmental parties, with no exception for claims brought under Spending Clause statutes.

B. The Framers Intended Federal Statutes Enacted Pursuant to The Spending Clause to Have Preemptive Force

The failure of the Articles of Confederation to establish federal supremacy had been especially damaging with regard to the federal government's inability to tax and spend for the defense and general interests of the nation. Under the Articles of Confederation, Congress could raise money only by making requests to the States, but the States failed to provide the requested funds "on a massive scale." Gillian E. Metzger, *To Tax, To Spend, To Regulate*, 126 HARV. L. REV. 83, 89 (2012). This created such an ineffectual central government that, according to George Washington, it nearly cost Americans victory in the Revolutionary War, and he lamented the dire situation in which the soldiers had been placed as a result of Congress's inability to levy taxes to support the Army. *See* 18 THE WRITINGS OF GEORGE WASHINGTON FROM THE ORIGINAL MANUSCRIPT SCOURES 1745-1799 453 (John C. Fitzpatrick ed., 1931) (Letter to Joseph Jones, May 31, 1780). The need "to provide adequate fiscal powers for the national government" motivated the Framers to write a new Constitution. Bruce Ackerman, *Taxation and the Constitution*, 99 COLUM. L. REV. 1, 6 (1999).

The Constitutional Convention sought to remedy this problem by authorizing Congress to raise and spend national funds for broad national goals. The initial proposal set forth by Governor Randolph began with the resolution "that the articles of

Confederation ought to be so corrected [and] enlarged as to accomplish the objects proposed by their institution; namely 'common defence, security of liberty, and general welfare.'" 1 RECORDS, at 20. Randolph suggested that Congress be assigned the power "to legislate in all cases to which the separate States are incompetent, or in which the harmony of the United States may be interrupted by the exercise of individual Legislation." *Id.* at 21. This assignment of broad legislative powers passed overwhelmingly. *Id.* at 47, 53-54. The Framers later added the power "to legislate in all cases for the general interests of the Union." 2 RECORDS, at 26-27.

The delegates gave directions for drafting the powers of the national legislative branch to the Committee of Detail, "which took upon itself the task of translating these instructions into the specific enumerations of Article I." AMAR, AMERICA'S CONSTITUTION, at 108 n.*. The delegates' instructions described the "legislative Rights vested in Congress" as including the authority "to legislate in all Cases for the general Interests of the Union, and also in those Cases to which the States are separately incompetent, or in which the Harmony of the United States may be interrupted by the Exercise of individual Legislation." RECORDS, Vol. 2, at 131-32. The Framers tied the broad legislative powers of Congress to the need to supplant individual state legislation.

The ultimate text of the Spending Clause in Article I was drafted by the Convention's Third Committee of Eleven. *Id.* at 481. The Committee of

Eleven added to Article I that Congress shall have the power to "provide for the common defence and general welfare of the United States." *Id.* at 493, 497. *Cf.* 1 RECORDS, at 20 (Randolph's first resolution seeking "common defence" and "general welfare").

As finalized, the text of the Spending Clause provides in pertinent part: "The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States . . . ." U.S. CONST. art. I, § 8, cl. 1. The Spending Clause is the first power, and one of the most sweeping powers, that the Constitution confers upon Congress. The Framers noted in their instructions to the Committee of Detail that laws for the general interests of the nation were needed to supersede more insular or ineffective state laws. 2 RECORDS, at 131-32. Thus, laws enacted pursuant to the Spending Clause's "general welfare" provision were clearly intended to have preemptive force.

Hamilton explained in the Federalist Papers that the power to tax and spend is "an indispensable ingredient in every constitution." THE FEDERALIST NO. 30 (Alexander Hamilton). He noted that it was essential for the Constitution to "embrace a provision for the support of the national civic list; for the payment of the national debts contracted, or that may be contracted; and, in general, for all those matters which will call for disbursements out of the national treasury." *Id.*

The text and history of the Spending Clause demonstrate the Framers' intent to provide Congress with broad spending powers in order to displace inadequate or parochial state legislation related to national issues. In early drafts, the Convention delegates described Congress's power as encompassing the "general Interests of the Union" and the "Harmony of the United States." The final text utilized the equally expansive term: "general Welfare of the United States." In all these iterations, the Founders conferred far-reaching powers on Congress to spend federal revenues for the benefit of the nation's people, supplanting contrary state laws.

Texas effectively seeks to relegate the Spending Clause to the status of a "poor relation" when it comes to the application of the Supremacy Clause to Spending Clause legislation, *c.f. Dolan v. City of Tigard*, 512 U.S. 374, 392 (1994), but the Spending Clause is as much a part of Article 1, Section 8 as the other enumerated powers, and this Court should reject this invitation.

II. More Than 200 Years of Precedent Support Judicial Review of the Conflict Between Federal and State Law In This Case

Texas contends that even if "North Carolina's statute fails to comport with provisions in the federal Medicaid Act," the conflicting state law is not preempted by federal law. Texas Br. 22. This argument is contrary to the balance of powers

established by the Constitution and enforced by the judicial branch for centuries.

Chief Justice Marshall eloquently explained the importance of the supremacy of federal law in our system of government:

> If any one proposition could command the universal assent of mankind, we might expect it would be this—that the government of the Union, though limited in its powers, is supreme within its sphere of action. This would seem to result, necessarily, from its nature. It is the government of all; its powers are delegated by all; it represents all, and acts for all. Though any one State may be willing to control its operations, no State is willing to allow others to control them. The nation, on those subjects on which it can act, must necessarily bind its component parts.

McCulloch v. Maryland, 17 U.S. 316, 405 (1819). Writing for this Court, Marshall noted that the "framers of our constitution foresaw" that states would pass laws conflicting with federal laws, and "[i]n every such case, the act of Congress, or the treaty, is supreme; and the law of the State, though enacted in the exercise of powers not controverted, must yield to it." *Gibbons v. Ogden*, 22 U.S. 1, 210-11 (1824). Marshall acknowledged the argument that the dignity of the state could be wounded by the "humiliation" of submitting to a judicial tribunal, but

the Chief Justice noted the "still superior dignity of the people of the United States." *Craig v. Missouri*, 29 U.S. 410, 437 (1830). He wrote for this Court that a state law "repugnant" to a federal statute will "furnish no authority" to those who relied upon the state statute. *Osborn v. Bank of US*, 22 U.S. 738, 859 (1824).

In the first century of this country's history, suits to enforce the supremacy of federal law were not limited to actions by government actors. Individuals bringing private suits readily obtained judicial review to determine whether a state law contravened federal law. *See, e.g., Gillman v. City of Phila.*, 70 U.S. 713, 722-24 (1866); *Dodge v. Woolsey*, 59 U.S. 331, 341 (1855); *New Jersey v. Wilson*, 11 U.S. 164, 166-67 (1812).

In 1908, in *Ex parte Young*, 209 U.S. 123 (1908), this Court firmly cemented the right of individuals to seek the protection of the judicial branch to obtain injunctive relief to invalidate a state law conflicting with federal law. As then–Associate Justice Rehnquist explained, *Ex parte Young* was a "watershed case" providing prospective relief that is "analogous" to the modern day injunction enjoining state officials from failing to comply with federal regulations. *Edelman v. Jordan*, 415 U.S. 651, 664 (1974). Justice Rehnquist reiterated a decade later that "the availability of prospective relief of the sort awarded in *Ex parte Young* gives life to the Supremacy Clause. Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the

supremacy of that law." *Green v. Mansour*, 474 U.S. 64, 68 (1985).

Justice Kennedy has similarly observed that "the whole jurisprudence of preemption" is of vital importance to "maintaining the federal balance." *United States v. Lopez*, 514 U.S. 549, 578 (1995) (Kennedy, J., concurring). As a result, even when there is no statutory right of action, private individuals may bring "pre-emption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes." *Golden State Transit Corp. v. City of L.A.*, 493 U.S. 103, 119 (1989) (Kennedy, J., dissenting). In recent years, this Court has "expanded the *Young* exception far beyond its original office" and "defined important limits on *Young* in order to respect state sovereignty while still adhering to principles necessary to implement the Supremacy Clause." *Va. Office of Prot. & Advocacy v. Stewart*, 131 S. Ct. 1632, 1642-43 (2011), (Kennedy, J., concurring). As Justice Kennedy wrote for the unanimous Court in a case involving the enforcement of Medicaid, private individuals may bring "suits for prospective injunctive relief against state officials acting in violation of federal law." *Frew v. Hawkins*, 540 U.S. 431, 437 (2004).

Throughout our nation's history, the judicial branch has fulfilled its constitutional duty to invalidate state statutes that conflict with federal law. This Court has continually emphasized the importance of its role in upholding the supremacy of federal law. More than 200 years of precedent

establish that a state law in direct conflict with federal statutory requirements cannot evade the force of the Supremacy Clause. Texas's argument to the contrary is novel—indeed, novel even within the confines of this litigation—and utterly without merit.

III. Medicaid's Lien Provisions Preempt Contrary State Laws and are Enforceable by Beneficiaries

Texas argues that the Medicaid statute "permits States to administer their Medicaid programs as they please . . . and then wait to see if the Secretary will turn off the spigot or merely reduce the amount of funding." Texas Br. 18. Texas's contention that the Medicaid statute permits states to ignore Medicaid's provisions regarding liens is contrary to the clear language of the statute and this Court's jurisprudence enforcing Medicaid.

Petitioner's Statement lists the relevant provisions in this case as 42 U.S.C. §§ 1396a(a)(25)(A), 1396a(a)(25)(B), 1396k(b), and 1396p(a)(1) (2006). Pet'r Br. 4-5. Texas contends that none of these provisions contains language similar to Title VI's mandatory statement: "No person in the United States shall . . . ." Texas Br. 18, citing 42 U.S.C. § 2000d (2006). But, simply reading the Medicaid statute shows otherwise.

To begin with, 42 U.S.C. § 1396p(a)(1) contains mandatory language prohibiting specific conduct. It provides: "No lien may be imposed against the property of any individual prior to his death on

account of medical assistance paid or to be paid on his behalf under the State plan." The words "No lien may be imposed" have the same proscribing effect as Title VI's command "No person . . . shall." The interpretation urged by Texas that a state may impose a lien in contravention of § 1396p(a)(1) if the state is willing to accept fewer federal dollars cannot be squared with the compulsory language of the statute.

The provisions of Medicaid addressing third-party liability, 42 U.S.C. §§ 1396a(a)(25)(A) and (B), are contained in an extensive list of Medicaid State plan requirements. The section begins with the phrase: "A State plan for Medical Assistance must . . . (a)(25) provide . . . ." 42 U.S.C. § 1396a(a)(25) (2006). Like the language of Title VI, this language is obligatory. Moreover, Congress has clarified that in a private "action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan." 42 U.S.C. §§ 1320a-2, 1320a-10 (2006). Congress has clearly expressed its intention that State plan requirements impose enforceable obligations on States.

The fourth applicable provision, 42 U.S.C. § 1396k (2006), similarly contains in section (a) the words, "a State plan for medical assistance shall . . . ." Then in section (b), the statute provides that part of the funds collected by the state "shall be retained by the State," and utilized for "appropriate reimbursement" of the federal government, but "the

remainder of such amount collected shall be paid to such individual." *Id.* The word "shall" is of course mandatory, and the phrases "shall be retained" and "shall be paid to such individual" are binding directives.

Texas is urging the Court to treat these mandatory Medicaid provisions as if they were optional. But that would be contrary to the express language of the statute and the clear intent of Congress as set out in the text.

Some provisions of Medicaid are indeed optional. For example, dental care for adults is not a mandatory Medicaid service but rather "*may* be furnished under the State plan *at the State's option*." 42 C.F.R. § 440.225 (2012) (emphasis added). *See* 42 U.S.C. § 1396d(a)(10) (2006). If a State declines to include optional services, such as dental care for adults, in its State plan, the State will not be violating federal law, but will simply receive less federal reimbursement. The Medicaid statute also permits the federal government to waive certain requirements for "demonstration projects" in which "the state expands its coverage in an experimental plan." *Spry v. Thompson*, 487 F.3d 1272, 1273-74 (9th Cir. 2007).

Neither Petitioner nor its *amici* claim that the federal government has waived the applicable provisions of the Medicaid statute in this case. Similarly, they do not deny, nor can they, that the relevant provisions are couched in mandatory terms.

Instead, Texas contends that the Medicaid provision regarding federal government oversight, 42 U.S.C. § 1396c, gives states total discretion whether or not to comply with the requirements of the Medicaid program. Texas Br. 21-22. Texas suggests that this provision renders all the mandatory language in Medicaid merely precatory and not preemptive. But there is nothing in the text of § 1396c that modifies the binding obligations imposed throughout the Medicaid statute.

This Court has repeatedly held that States choosing to participate in the federal Medicaid program must comply with the mandatory provisions of Medicaid. For instance, this Court instructed that "State participation is voluntary; but once a State elects to join the program, it must administer a state plan that meets federal requirements." *Frew v. Hawkins*, 540 U.S. 431, 433 (2004). *Accord Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Atkins v. Rivera*, 477 U.S. 154, 156-57 (1986); *Alexander v. Choate*, 469 U.S. 287, 289 n.1, (1985); *Harris v. McRae*, 448 U.S. 297, 301 (1980).

The argument that the federal power to terminate funds precludes private enforcement of Medicaid has been made before in this Court but has never held sway. *See, e.g., PhRMA v. Walsh*, 538 U.S. 644, 675 (2003) (Scalia, J., concurring). In fact, in the *Ahlborn* case brought by a Medicaid beneficiary, this Court unanimously held that an Arkansas law was "unenforceable," because the state statute permitted a lien in contravention of the same Medicaid provisions at issue in the instant case. 547

U.S. 268, 292 (2006). The unanimous Court noted that in return for federal Medicaid funds, States must "compl[y] with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program." *Id.* at 275. In *Ahlborn*, this Court held that the mandatory lien provisions applicable in this case have preemptive effect.

Similarly, in the context of private suits under 42 U.S.C. § 1983, this Court has rejected the argument that the federal government's power to reduce funding precludes private enforcement. The Court explained that "the Secretary's oversight powers are not comprehensive enough to close the door on § 1983 liability." *Blessing v. Freestone*, 520 U.S. 329, 348 (1997). The ability of the federal government to withhold approval of Medicaid State plans and "to curtail federal funds to States whose plans are not in compliance with the Act" does not "withdraw the private remedy under § 1983." *Wilder*, 496 U.S. at 521-22. *Accord Golden State Transit Corp. v. City of L.A.*, 493 U.S. 103, 106 (1989); *Wright v. City of Roanoake Redevelopment and Housing Authority*, 479 U.S. 418, 428 (1987).

Texas's reliance on *NFIB* is misplaced. Texas argues that *NFIB* held that "States may choose to violate conditions in the Affordable Care Act and accept a reduction in federal Medicaid reimbursement." Texas Br. 20. This interpretation is baseless. In *NFIB*, the plurality opinion by Chief Justice Roberts stated:

> Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and *requiring that States accepting such funds comply with the conditions on their use.* What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.

Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB), 132 S. Ct. 2566, 2607 (2012) (emphasis added). The plurality indicated that States accepting Medicaid funds must follow federal directives when spending those funds, directly contradicting the interpretation urged by Texas.

Regarding the new program of expanded eligibility for adults established in the Affordable Care Act, Chief Justice Roberts's opinion crafted a remedy that prohibited the federal government from taking away existing Medicaid funds from states choosing not to implement the expansion. *Id.; see also id.* at 2642 (Ginsburg, J., concurring in part and dissenting in part) (agreeing with plurality regarding the "appropriate remedy"). Under this remedy, the expansion of Medicaid eligibility for higher income adults became optional, similar to dental benefits for adults. *NFIB* limited this remedy to the expanded eligibility for adults in the Affordable Care Act and did not render any other provision of Medicaid optional. And *NFIB* confirmed that if funds are accepted for an optional component, applicable

statutory requirements are mandatory and enforceable.

NFIB reinforces and does not in any way undermine the extensive precedent that treats provisions in all federal laws, including Medicaid, as preempting contrary state laws. The argument urged by Texas has no basis in any precedent of this Court and is contrary to the text and history of the Constitution and the clear language of the Medicaid statute.

CONCLUSION

The decision of the U.S. Court of Appeals for the Fourth Circuit should be affirmed.

Respectfully submitted,

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December 17, 2012

AMICUS CURIAE BRIEF

No. 12-98

IN THE

Supreme Court of the United States

ALBERT A. DELIA, ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

E.M.A. (BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON), WILLIAM EARL ARMSTRONG, AND SANDRA ARMSTRONG,

Respondents.

On Writ of Certiorari to the United States Court of Appeals For the Fourth Circuit

AMICI CURIAE BRIEF OF THE AMERICAN ASSOCIATION FOR JUSTICE AND THE NORTH CAROLINA ADVOCATES FOR JUSTICE IN SUPPORT OF RESPONDENTS

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IDENTITY AND INTEREST OF *AMICI CURIAE*

The American Association for Justice ("AAJ") and the North Carolina Advocates for Justice ("NCAJ") respectfully submit this brief as *amici curiae*.[1] Letters from the parties giving consent to the filing of this amicus brief accompany this filing.

AAJ is a voluntary national bar association whose members primarily represent plaintiffs in civil actions brought under state tort law. NCAJ is AAJ's affiliated state association in North Carolina. Many of the injured plaintiffs represented by AAJ and NCAJ members have received or will receive medical treatment for their injuries paid for by Medicaid. As a result, *amici*'s members and their clients are directly affected by the construction of statutory provisions in the federal Medicaid Act concerning repayment of medical expenses to state Medicaid agencies out of proceeds obtained from liable third parties through litigation.

AAJ participated in this Court's prior consideration of the relevant Medicaid lien provisions in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), as *amicus curiae* under its former name, the Association of Trial Lawyers of America ("ATLA"). And this Court favorably cited to the ATLA *amicus* brief to support the proposition that "some States have adopted special rules and procedures for allocating

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[1] Pursuant to Supreme Court Rule 37.6, *Amici* disclose that no counsel for a party authored any part of this brief, nor did any person or entity other than *Amici Curiae*, their members, or their counsel make a monetary contribution to the preparation or submission of this brief.

tort settlements . . . [that] might be employed to meet concerns about settlement manipulation." *Id.* at 288 n.18 (citing ATLA Amicus Br. at 20-21, *Arkansas Dep't of Health & Human Serv. v. Ahlborn*, 547 U.S. 268 (2006) (No. 04-1506) (hereinafter "ATLA Amicus Br.")).

Petitioner repeatedly and incorrectly points to that language from the *Ahlborn* decision in support of his argument that N.C. Gen. Stat. § 108A-57 complies with this Court's holding in that case. Pet'r's Br. 19, 23, 27. AAJ and NCAJ therefore submit this brief *amici curiae* in order to correct Petitioner's inaccurate reliance on the prior ATLA brief, to demonstrate that the anti-lien provision of the Medicaid Act requires a fair and reasonable allocation of any settlement among past medical expenses paid by Medicaid and other categories of damage based on the facts of a particular case, and to explain how such an allocation advances the purposes of the Act.

SUMMARY OF ARGUMENT

The federal Medicaid Act generally prohibits states from imposing liens against, or seeking recovery of benefits paid from, a Medicaid recipient. 42 U.S.C. § 1396p. In *Ahlborn*, this Court unanimously concluded that this "anti-lien" provision prohibited state Medicaid agencies from seeking reimbursement for medical expenses they had paid out of any portion of a court judgment or settlement the recipient obtained from a third party apart from that portion of the judgment or settlement that represented payment for past medical expenses. 547 U.S. at 284-85. *Ahlborn* instructed States and Medicaid recipients to determine what portion of a

settlement represented such payments either by mutual agreement or by "submitting the matter to a court for decision." *Id.* at 288.

The North Carolina Medicaid lien statute at issue in this case, N.C. Gen. Stat. § 108A-57, like the Arkansas provision invalidated in *Ahlborn*, asserts a claim for reimbursement of medical expenses paid without regard to the actual portion of a settlement that represents payment for past medical expenses, up to one-third of the total recovery. Petitioner asserts that this statute complies with *Ahlborn* because the Medicaid Act permits states to unilaterally decide how settlements are apportioned, without regard to the facts of a particular case. Pet'r's Br. 16-20. As the Court of Appeals recognized, this argument is contrary to *Ahlborn* and the anti-lien provision of the Medicaid Act. Any settlement must be fairly and reasonably allocated between past medical expenses and other items of damage either by mutual agreement of the parties or by the decision of a court.

The North Carolina statute cannot be upheld as one of the "special rules and procedures" adopted by some states that the *Ahlborn* Court referenced. 547 U.S. 288 n.18. The Court, relying on information provided in the *amicus* brief submitted by ATLA, was referring to procedures for judicial allocation of settlements, not to unilateral "rule[s] of absolute priority" that a state might adopt by statute or regulation.

Petitioner argues that judicial allocation proceedings are "untenable," but many other states have successfully implemented such procedures to comply with *Ahlborn*. Indeed, North Carolina itself

already uses a very similar hearing procedure to allocate settlements subject to workers' compensation liens. While such proceedings undoubtedly place certain burdens on state Medicaid agencies, those costs are necessitated by the anti-lien requirement of Medicaid and are ameliorated by Medicaid recipients' statutory duty to cooperate with the State in pursuing third-party reimbursements. 42 U.S.C. § 1396k(a). And the state Medicaid agency always remains free to pursue its reimbursement claim directly against the potentially liable third party.

A fair and reasonable allocation of third-party recoveries advances important public policy interests, provides incentives for injured Medicaid beneficiaries to pursue potentially liable third parties, and promotes the efficient resolution of lawsuits. Consequently, such allocations likely increase total third-party reimbursements to Medicaid.

ARGUMENT

I. THE NORTH CAROLINA THIRD-PARTY PAYMENT STATUTE, N.C. GEN. STAT. § 108A-57, DOES NOT COMPLY WITH THE ANTI-LIEN PROVISION OF THE FEDERAL MEDICAID ACT, WHICH REQUIRES THAT RECOVERIES FROM THIRD PARTIES BE FAIRLY AND REASONABLY ALLOCATED BETWEEN PAST MEDICAL EXPENSES AND OTHER DAMAGES.

A. This Court's Decision in *Ahlborn* Requires Such an Allocation.

The federal Medicaid Act requires participating states "to ascertain the legal liability of third parties . . . to pay for care and services available under the plan," 42 U.S.C. § 1396a(a)(25)(A), and, where a state Medicaid agency has paid for medical treatment, to "seek reimbursement for such assistance to the extent of such legal liability." *Id.* § 1396a(a)(25)(B). The act also requires that Medicaid recipients "assign the State any rights . . . to payment for medical care from any third party." *Id.* § 1396k(a)(1)(A). At the same time, however, the federal statute "places express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf." *Ahlborn*, 547 U.S. at 283. In particular, 42 U.S.C. § 1396p "prohibits States (except in circumstances not relevant here) from placing liens against, or seeking recovery of benefits paid from, a Medicaid recipient." *Id.*[2]

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[2] Section 1396p provides, in relevant part:

In *Ahlborn*, this Court addressed the tension between these third-party liability and anti-lien provisions. The Court concluded that the Medicaid Act limited the State's right to reimbursement to that portion of any court judgment or settlement that represented repayment of past medical expenses paid for by Medicaid:

> [T]he State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§ 1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of

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> (a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan
>
> > (1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, [except in certain circumstances not relevant here]. . . . .
>
> (b) Adjustment or recovery of medical assistance correctly paid under a State plan
>
> > (1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, [except in circumstances not relevant here].

42 U.S.C. § 1396p.

> Medicaid eligibility that the recipient "assign" in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.

547 U.S. at 284-85 (citation omitted).

In *Ahlborn*, there was no dispute that approximately one-sixth of Ms. Ahlborn's tort settlement "constitute[d] reimbursement for medical costs." *Id.* at 285. Nevertheless, this Court offered guidance about how the interests of both the State and the Medicaid recipient could be protected in future cases: "either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Id.* at 288.[3]

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[3] It was in this context that the Court cited the ATLA *amicus* brief:

> As one *amicus* observes, some States have adopted special rules and procedures for allocating tort settlements in circumstances where, for example, private insurers' rights to recovery are at issue. See Brief for Association

Under either approach sanctioned by this Court, the allocation of a settlement between past medical expenses and other categories of damages is likely to be fair and equitable to all parties. If the State and the Medicaid recipient can agree on an allocation then, by definition, each is satisfied with the outcome. Alternatively, submission of the matter to a court ensures that a neutral adjudicator will determine a rational allocation based on the particular facts in that case.

These two approaches contrast sharply with the two unilateral alternatives that this Court rejected in *Ahlborn*. On the one hand, the Court recognized that it would not be appropriate simply to

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> of Trial Lawyers of America 20-21. Although we express no view on the matter, we leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation.

Id. at 288 n.18. The Court's citation was to a passage in the ATLA brief that discussed post-settlement procedures employed by courts in Minnesota, Wisconsin, and other jurisdictions "to allocate settlement proceeds between categories of damages" for subrogation purposes. ATLA Amicus Br. 20-21. The Solicitor General's brief in *Ahlborn* acknowledged similar "post-settlement hearings to allocate settlements between taxable and non-taxable income categories." *Id.* at 20 (citing U.S. Amicus Br. at 17 n.7, *Arkansas Dep't of Health & Human Serv. v. Ahlborn*, 547 U.S. 268 (2006) (No. 04-1506)).

Thus, there can be no question that this Court's reference to "special rules and procedures" adopted by some States referred to rules and procedures for such post-settlement allocation hearings, not to state statutes that automatically and arbitrarily impose a rule of "absolute priority" for reimbursement of Medicaid payments. *Ahlborn*, 547 U.S. at 288.

allow the plaintiff and the defendant in the underlying litigation to decide—without the State's involvement—how much of a settlement represented past medical expenses reimbursable to the state Medicaid agency; such an approach would run a "risk of settlement manipulation" that could "allocate away the State's interest." *Id.*[4] On the other hand, the Court also recognized that it would be equally inappropriate to allow the State to grant itself "absolute priority" in reimbursement of its Medicaid expenditures; such a rule could "preclude settlement in a large number of cases, and be unfair to the recipient in others." *Id.*

Thus, *Ahlborn* instructs that, where the State and the Medicaid recipient cannot agree on an equitable allocation of a third-party recovery, the matter should be submitted to a neutral adjudicator for resolution. The Court of Appeal's conclusion that this case must be remanded for "a fair and impartial adversarial procedure," Pet. App. 55a, is entirely consistent with this Court's guidance.[5]

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[4] Petitioner's Brief seems to assume throughout that the alternative to N.C. Gen. Stat. § 108A-57 is a regime in which Medicaid recipients and third-party payors can manipulate away the State's interest by structuring settlements to minimize or eliminate the State's interest in reimbursement. Pet'r's Br. 30-33. That is simply not the case. As *Ahlborn* makes clear, such unilateral manipulation of settlements is just as problematic as the State's rule of absolute priority. And, quite obviously, the decision below does not countenance such manipulation; the Court of Appeals remanded this matter "for an evidentiary hearing at which the district court shall determine the proper amount of DHHS's Medicaid lien in this case." Pet. App. 55a.

[5] The vast majority of post-*Ahlborn* decisions have similarly concluded that, absent agreement, the proper

B. N.C. Gen. Stat. § 108A-57 Is Just as Much a "Rule of Absolute Priority" as the Arkansas Statutory Scheme Invalidated in *Ahlborn*.

N.C. Gen. Stat. § 108A-57 does not provide for any "fair and impartial adversarial procedure" to allocate settlements between medical and other damages.[6] Instead, without regard to the facts and circumstances in a particular case, it mandates full repayment of any medical expenses paid by Medicaid up to a fixed statutory cap. In all relevant respects, it is indistinguishable from the Arkansas statutory scheme invalidated in *Ahlborn*. It establishes a "rule of absolute priority," improperly privileging the State's interest in Medicaid repayment over the Medicaid recipient's interest in recovery of her non-medical damages.

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allocation of a settlement between reimbursable medical expenses and other items of damage must be determined by an impartial adjudicator based on the particular facts of the case. *See, e.g., Tristani v. Richman*, 652 F.3d 360 (3d Cir. 2011); *Price v. Wolford*, 608 F.3d 698 (10th Cir. 2010); *Southwest Fudiciary v. Arizona Healthcare Cost Containment Sys. Admin.*, 249 P.3d 1104 (Ariz. Ct. App. 2011); *Lima v. Vous*, 94 Cal. Rptr. 3d 183 (Cal. Ct. App. 2009); *Bolanos v. Superior Court*, 87 Cal. Rptr. 3d 174 (Cal. Ct. App. 2008); *Roberts v. Albertson's, Inc.*, No. 4D10-2313, 2012 WL 5232182 (Fla. 4th DCA Oct. 24, 2012); *Smith v. Agency for Health Care Admin.*, 24 So. 3d 590 (Fla. 5th DCA 2009); *Chambers v. Jain*, 839 N.Y.S.2d 432 (N.Y. Sup. Ct. 2007); *Lugo v. Beth Israel Med. Ctr.*, 819 N.Y.S.2d 892 (N.Y. Sup. Ct. 2006); *McKinney v. Philadelphia Hous. Auth.*, No. 07-4432, 2010 WL 3364400 (E.D. Pa. Aug. 24, 2010); *In re E.B.*, 729 S.E.2d 270 (W. Va. 2012).

[6] Nor, for that matter, does that statue appear to permit the State to reach an agreement with the Medicaid recipient for a lesser reimbursement of medical expenses paid by Medicaid, the other form of allocation sanctioned in *Ahlborn*.

In *Ahlborn*, the state of Arkansas "claim[ed] an entitlement to more than just that portion of a judgment or settlement that represents payment for medical expenses. It claim[ed] a right to recover the entirety of the costs it paid on the Medicaid recipient's behalf." 547 U.S. at 278. This was so "even when the parties to the settlement allocate damages between medical costs, on the one hand, and other injuries like lost wages, on the other. The same rule also would apply, it seems, if the recovery were the result not of a settlement but of a jury verdict." *Id.* at 278-79.

N.C. Gen. Stat. § 108A-57 operates in almost exactly the same way. It does not limit the State's claim for reimbursement to that portion of a settlement or judgment that represents past medical expenses. To the contrary, it provides: "to the extent of payments under this Part, the State . . . shall be subrogated to *all rights of recovery*, contractual or otherwise, of the beneficiary of this assistance, . . . *against any person*." N.C. Gen. Stat. § 108A-57(a) (emphasis added). It orders the beneficiary's attorney to pay the state Department of Health and Human Services ("NCDHHS") "*the amount of assistance paid by the Department* on behalf of or to the beneficiary . . . out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party." *Id.*[7]

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[7] The North Carolina statute provides that the Department's claim for reimbursement must be "prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered." *Id.* This provision, which protects not the Medicaid beneficiary but rather other health care providers, reinforces the conclusion

If the State's Medicaid expenses amount to less than one-third of the beneficiary's recovery, North Carolina claims an entitlement to be reimbursed in full, even where the beneficiary had to compromise her claim for a fraction of its worth.[8] And, while N.C. Gen. Stat. § 108A-57 caps the State's reimbursement claim at one-third of any recovery, that limitation in no way represents an appraisal of the value of the beneficiary's other damages. Rather, that provision is primarily intended to ensure that funds are available to pay plaintiff's attorneys' fees and litigation costs, so that the State can take a free ride on the beneficiary's damage claims. Petitioner comes close to conceding as much in its brief. Pet'r's Br. 25 ("This ensures that the recipient has access to the majority of the proceeds to pay attorneys fees and costs . . . .").[9]

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that the State's reimbursement claim is not to be prorated with other, non-medical damages suffered by the beneficiary.

[8] There are many reasons why a plaintiff may decide to settle a case for less than full value, such as the inherent risks of litigation, the increased cost of taking a case to trial, problems of proof, a potential finding of contributory or comparative negligence, or limitations on the defendant's ability to pay full compensation.

[9] Evidence that the reimbursement cap in N.C. Gen. Stat. § 108A-57 was not intended to function as a reasonable allocation between medical care and other damages can be found in the statute's history and structure. To begin, N.C. Gen. Stat. § 108A-57 was enacted prior to *Ahlborn*, when the State believed that the Medicaid third-party recovery provisions entitled it to full reimbursement. Moreover, as Petitioner acknowledges, Pet'r's Br. 22-23 & n.4, section 108A-57 is functionally equivalent to a separate pair of North Carolina statutes governing private medical liens, N.C. Gen. Stat. §§ 44-49 and 44-50; yet, unlike Medicaid liens, such private liens are not limited by the anti-lien provision to recoveries representing

Moreover, nothing in Petitioner's argument turns on the existence of the cap. By its reasoning, an "advance allocation" of full repayment to the State before the beneficiary recovers anything for her non-medical damages with no cap would presumably be an equally valid exercise of the State's purported authority to "define the amount of a damage award representing compensation for past medical expenses." Pet'r's Br. 17.

The only meaningful difference between the present case and *Ahlborn* is that in the former case the state of Arkansas stipulated to the portion of Ms. Ahlborn's settlement that represented repayment of medical expenses, whereas North Carolina has not agreed to an allocation in this case. By Petitioner's reasoning, Arkansas would have prevailed in *Ahlborn* if only it had not foolishly agreed to stipulate to the fair allocation of damages.

But that flawed reasoning cannot be squared with this Court's holding. E.M.A. suffered real and substantial injuries, including but not limited to medical damages, and the settlement of her claims necessarily compromised all of her claimed damages. Under *Ahlborn*, in order to protect her property interest in her other categories of damage, the anti-lien provision of the Medicaid Act requires that the settlement be fairly and equitably allocated among the various "heads of damages," 547 U.S. at 282 n.12,

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repayment of past medical expenses. Finally, by its terms, N.C. Gen. Stat. § 108A-57 applies not just to settlements, but also to judgments; thus, its award of up to one-third of any recovery to the state would seem to apply even in the fact of a contrary judicial determination regarding the proper allocation of a judgment among various items of damages.

either by mutual agreement between the parties or by an impartial adjudicator. *Id.* at 288; *see also In re E.B.*, 729 S.E.2d at 288-91 (rejecting argument that "*Ahlborn* is limited to cases where the parties have stipulated to the value of the plaintiff's claim" and invalidating West Virginia lien statute that, like N.C. Gen. Stat. § 108A-57, capped state Medicaid reimbursements at one third of an unallocated settlement).

Petitioner purports to find support for its position in this Court's footnoted reference to "special rules and procedures" that some States have adopted for allocating tort settlements. Pet'r's Br. 19, 23, 27. But that passage in *Ahlborn* clearly refers to rules and procedures by which a court can allocate damages, not to statutory provisions guaranteeing the state automatic priority. 547 U.S. at 288 n.18 & text accompanying note (footnote accompanies textual reference to "submitting the matter to a court for decision").

As noted earlier, *supra* pp.6-8, the *Ahlborn* court supported its reference to "special rules and procedures" with a citation to the *amicus* brief submitted by ATLA. A review of that passage of the brief is instructive:

> Where the parties cannot agree on an equitable division of the settlement proceeds, the trial court should convene a hearing to undertake such a division. All claimants—including those, like the state Medicaid agency, that have acquired their rights by assignment or subrogation—would receive notice of the hearing and an

opportunity to be heard on the value of various items of damage in the case and a fair distribution of the funds.

Such a post-settlement allocation hearing would not be unusual. As the Brief for the United States acknowledges, courts may "conduct post-settlement hearings to allocate settlements between taxable and non-taxable income categories." Brief for the United States at 17, n.7 (citing cases). Similarly, a number of states already have well-developed procedures in place for allocating the proceeds from a tort settlement. In Minnesota, for example, trial courts can convene a so-called "*Henning* hearing" to allocate settlement proceeds between categories of damages recoverable by a subrogated insurer and non-recoverable damages. *See Henning v. Wineman*, 306 N.W.2d 550 (Minn. 1981). To the same end, the Wisconsin Supreme Court has upheld a trial court's use of a "*Rimes* hearing," a post-settlement "mini-trial" to allocate proceeds. *See Rimes v. State Farm Mutual Automobile Ins. Co.*, 316 N.W.2d 348 (Wisc. 1982).

In the experience of these states, once such a hearing procedure is developed, it is rarely used. Once all of the interested claimants understand the rules that govern the division of settlement proceeds, it is usually possible for them to agree to an

> allocation without the need for the time and expense of an allocation hearing. *See* Sharon L. Van Dyck & Wilbur W. Fluegel, *Determining "Full Recovery" Under the Minnesota Anti-Subrogation Statute*, Minn. Trial Lawyer Mag. 18 (Winter 1999).

ATLA Amicus Br. 20-21 (footnotes omitted).

Amicus recognized, as did this Court, 547 U.S. at 288 n.18 ("we express no view on the matter"), "that it would be inappropriate . . . for this Court to establish specific procedures for state court judicial proceedings to allocate settlement proceeds." ATLA Amicus Br. 21. *Amicus* nevertheless outlined these procedures (1) "to reassure the Court that there are workable procedures for resolving issues of equitable apportionment that need not burden trial courts with onerous satellite litigation proceedings" and (2) "to encourage this Court to articulate standards for equitable allocation of settlement proceeds in cases involving Medicaid in order to guide the orderly development of such procedures in state courts." *Id.* at 21-22.

Thus, this Court's discussion of "special rules and procedures" provides no support for North Carolina's statutory reimbursement scheme. N.C. Gen. Stat. § 108A-57 is just as much a "rule of absolute priority" as the Arkansas statutes invalidated in *Ahlborn*. And it violates the anti-lien provision of the federal Medicaid Act for precisely the same reasons.

II. MANY STATES USE EVIDENTIARY HEARINGS TO ALLOCATE SETTLEMENTS BETWEEN REIMBURSABLE MEDICAL EXPENSES AND OTHER CATEGORIES OF DAMAGES; NORTH CAROLINA ITSELF EMPLOYS A SIMILAR PROCEDURE TO ALLOCATE SETTLEMENTS SUBJECT TO WORKERS' COMPENSATION LIENS.

Even though this Court expressly identified a judicial proceeding as the appropriate forum for allocating a settlement where the parties cannot agree, 547 U.S. at 288, Petitioner argues that such a hearing is "untenable." Pet'r's Br. 27. Of course, that contention ignores the existing judicial procedures for allocating tort settlements that this Court referenced in *Ahlborn*. 547 U.S. at 288 n.18. It also overlooks the fact that other states have successfully used court hearings to implement the allocation that *Ahlborn* requires. Most strikingly, Petitioner's argument is refuted by North Carolina's own statutory procedure for allocating settlements involving workers' compensation liens.

A. Other States Have Successfully Implemented Hearing Procedures to Comply with *Ahlborn*.

California amended its state code provisions governing Medicaid liens in response to the *Ahlborn* ruling. Amended Cal. Welf. & Inst. Code § 14124.76, subd. (a), provides:

> No settlement, judgment, or award in any action or claim by a beneficiary to recover damages for injuries, where the

director has an interest, shall be deemed final or satisfied without first giving the director notice and a reasonable opportunity to perfect and to satisfy the director's lien. *Recovery of the director's lien from an injured beneficiary's action or claim is limited to that portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary.* All reasonable efforts shall be made to obtain the director's advance agreement to a determination as to what portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided [on] behalf [of] the beneficiary. *Absent the director's advance agreement . . . , the matter shall be submitted to a court for decision.* Either the director or the beneficiary may seek resolution of the dispute by filing a motion, which shall be subject to regular law and motion procedures. In determining what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary and as to what the appropriate reimbursement amount to the director should be, the court shall be guided by the United States Supreme Court decision in *Arkansas Department of Health and Human Services v. Ahlborn* (2006) 547 U.S. 268 and other relevant statutory and case law.

Id. (emphasis added). The amended statute has been successfully employed to resolve allocation disputes in multiple cases. *See, e.g., Lima*, 94 Cal. Rptr. 3d 183; *Bolanos*, 87 Cal. Rptr. 3d 174.

Missouri similarly amended its state code provision to provide for an evidentiary hearing to allocate damages. Mo. Rev. Stat. §§ 208.215.9-.11. The amended provision expressly authorizes a court to "reduce and apportion the [State's] lien proportionate to the recovery of the claimant." *Id.* at § 208.215.11. It further invites the court to take into account, *inter alia*, "the nature and extent of the injury, economic and noneconomic loss, settlement offers, [and] comparative negligence as it applies to the case at hand." Missouri courts have had no difficulty in using this statutory hearing process to reduce state Medicaid liens. *See, e.g., American Family Mut. Ins. Co. v. Fehling*, 970 S.W.2d 844 (Mo. Ct. App. 1998).

Pennsylvania likewise amended its statutory law in order to authorize courts to allocate damages. After payment of attorneys' fees and litigation costs, a court shall allocate a settlement "between the medical portion and other damages and shall allow the department a first lien against the medical portion of the judgment or award, the amount of the expenditures for the benefit of the beneficiary under the medical assistance program." 62 Pa. Cons. Stat. § 1409.1(b)(1). If a court fails to allocate a settlement, the state will presume that one-half of the settlement (after payment of legal costs and fees) constitutes repayment of medical expenses, but the beneficiary may dispute that presumption in an administrative hearing. 62 Pa. Stat. Ann. § 1409(b)(11); 55 Pa. Code § 259.2(d). The Third Circuit has held that this

administrative review process is required by *Ahlborn*; without it, the presumptive statutory allocation would violate the anti-lien provision of the Medicaid act. *Tristani*, 652 F.3d at 378.

Oklahoma also amended its Medicaid lien provisions in response to *Ahlborn*. The amended statute presumes that a settlement includes full repayment of any expenses incurred by Medicaid, "unless a more limited allocation of damages to medical expenses is shown by clear and convincing evidence." Okla. Stat. tit. 63, § 5051.1(D)(1)(d).[10] In *Price v. Wolford*, 608 F.3d 698 (10th Cir. 2010), the Court of Appeals identified the kind of evidence that would justify a reduction in a lien under the statute:

> [A] reduction in a Medicaid lien can be justified only by showing a reason why the plaintiff would agree to allow the defendant to pay less than the full amount of the Medicaid lien. The usual reasons would be that the liability of the settling defendant is uncertain or, that the defendant lacks the money to pay for his full liability (or both); so the plaintiff would be willing to take a proportionate reduction in each component of the damages that she would expect the jury to award if the defendant were found liable.

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[10] *Amici* do not concede that Oklahoma's use of the clear and convincing evidence standard complies with the anti-lien provision as construed in *Ahlborn* or the beneficiary's constitutional right to due process of law. *Mathews v. Eldridge*, 424 U.S. 319, 321 (1976) (due process requires consideration of "the risk of an erroneous deprivation of [the Medicaid beneficiary's] interest through the procedures used").

Id. at 707. The Court of Appeals in this case found this discussion helpful. Pet. App. 50a-51a n.12 (relying on this discussion in *Price*).

None of these states appear to find the allocation hearing contemplated by *Ahlborn* "untenable." To the contrary, they all have found a way to fulfill their federal third-party-recovery obligations while respecting and protecting their Medicaid beneficiaries' independent interest in receiving compensation for their injuries.

B. North Carolina Has Long Relied On Similar Evidentiary Hearings to Allocate Settlements Involving Workers' Compensation Liens.

Strikingly, North Carolina already regularly utilizes a hearing procedure that is quite similar to the process it now derides as "untenable" to allocate settlements subject to workers' compensation liens. Under N.C. Gen. Stat. § 97-10.2, where an employer pays workers' compensation benefits to an employee for injuries for which a third party may be liable, the employer—and its insurance carrier—obtain a subrogation interest to reimbursement out of any third-party recovery, much like NCDHHS here. The amount to be repaid out of a settlement with the third party is determined through an evidentiary hearing before the court:

> [I]n the event that a judgment is obtained by the employee in an action against a third party, or in the event that a settlement has been agreed upon by the employee and the third party, either party may apply to the resident

> superior court judge of the county in which the cause of action arose or where the injured employee resides, or to a presiding judge of either district, to determine the subrogation amount. After notice to the employer and the insurance carrier, after an opportunity to be heard by all interested parties, and with or without the consent of the employer, the judge shall determine, in his discretion, the amount, if any, of the employer's lien, whether based on accrued or prospective workers' compensation benefits, and the amount of cost of the third-party litigation to be shared between the employee and employer. The judge shall consider the anticipated amount of prospective compensation the employer or workers' compensation carrier is likely to pay to the employee in the future, the net recovery to plaintiff, the likelihood of the plaintiff prevailing at trial or on appeal, the need for finality in the litigation, and any other factors the court deems just and reasonable, in determining the appropriate amount of the employer's lien.

N.C. Gen. Stat. § 97-10.2(j).

When the injured worker is a state employee, the state is subject to these hearing procedures to determine the amount of worker's compensation payments it will recoup. *See* N.C. Gen. Stat. § 97-7 (state and its employees are covered by workers' compensation law). Petitioner offers no evidence that

these allocation procedures, long employed throughout North Carolina, have proven to be "untenable."

Petitioner's real concern seems to have less to do with "tenability" than with time and expense. North Carolina recognizes that it would have to expend time and effort in judicial allocation hearings. Pet'r's Br. 15, 27-28. The state would much prefer simply to take a free ride on the plaintiff's litigation efforts, recouping automatic lien repayments without any expenditure on its part.

But such a free ride does not comply with Medicaid's anti-lien provision, which protects a beneficiary's independent property interest in her non-medical damages. Indeed, as this Court recognized without deciding in *Ahlborn*, there is a strong argument that the anti-lien provision bars any State lien claim against a judgment or settlement obtained by a Medicaid beneficiary. 547 U.S. at 284 ("Read literally and in isolation, the anti-lien prohibition contained in § 1396p(a) would appear to ban even a lien on that portion of the settlement proceeds that represents payments for medical care."); *see also Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002); *Tristani*, 652 F.3d at 379 (Pollak, J., dissenting); *Wallace v. Estate of Jackson*, 972 P.2d 446, 449 (Utah 1998) (Durham, C.J., dissenting) (all adopting this position). All of the third-party recovery provisions of the federal law seem to presume that it is the state Medicaid agency, not the beneficiary, which will engage in litigation to recoup medical expenses from liable third parties. The beneficiary must assign her interest in a claim for such expenses to the State, which has a subrogation right to pursue that claim in litigation.

42 U.S.C. §§ 1396a(a)(25)(H) and 1396k(a)(1)(A). The State must distribute any excess medical assistance reimbursements it collects to the beneficiary. *Id.* § 1396k(b). And Medicaid beneficiaries must cooperate with the State in obtaining payments and in identifying and providing information to assist the State in pursuing liable third parties. *Id.* § 1396k(a)(1)(B) and (C).[11] Participation in a judicial allocation hearing is ultimately far less burdensome for the State than being compelled to pursue reimbursement claims itself.

III. A FAIR AND REASONABLE ALLOCATION OF THIRD PARTY RECOVERIES CREATES APPROPRIATE INCENTIVES FOR MEDICAID RECIPIENTS TO PURSUE RECOVERY OF MEDICAL EXPENSES PAID BY MEDICAID, ENCOURAGES EFFICIENT RESOLUTION OF LAWSUITS, AND LIKELY INCREASES MEDICAID REIMBURSEMENTS.

As this Court recognized in *Ahlborn*, there are also important public policy arguments against a rule like N.C. Gen. Stat. § 108A-57 that automatically prioritizes the State's claim for reimbursement over the Medicaid beneficiary's claim for other damages. 547 U.S. at 288 ("a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient

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[11] This duty of cooperation also answers Petitioner's concern that the State would be at a disadvantage in an allocation hearing. Pet'r's Br. 28-29. The beneficiary and her counsel are obliged to provide relevant information requested by the State to assist it in asserting its lien.

in others"). *Amici* wish here to briefly emphasize three such concerns, each of which ATLA raised in its earlier brief. *See* ATLA Amicus Br. 9-19.

First, the North Carolina statute discourages injured Medicaid beneficiaries from pursuing recompense for their injuries. Prospective counsel would be obliged to advise a potential plaintiff that any recovery she obtained would be reduced by the full amount of reimbursement due to the state agency up to one third of the total recovery, as well as by the payment of attorneys' fees and costs (to which the State would not contribute). In many cases, these items could amount to close to 75 percent of any potential recovery. If the success of the litigation is in doubt—due to either problems of proof or concerns about the defendant's ability to pay damages—the beneficiary and her counsel might well conclude that the potential reward is not worth the time, effort, and expense of pursuing litigation.[12]

Second, N.C. Gen. Stat. § 108A-57 discourages settlements and impedes the efficient resolution of legal disputes. This Court has long recognized a strong public interest in the expeditious resolution of lawsuits through settlements. *See, e.g., McDermott,*

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[12] Even if the potential plaintiff is willing to proceed with a suit for damages, she may have difficulty in obtaining competent counsel to represent her on a contingent fee basis. Counsel may well be reluctant to represent a client who is unlikely to realize any significant recovery after repayment of a Medicaid lien, regardless of the merits of the litigation. Moreover, because the State does not contribute in any way to the fees and costs of litigation, counsel may be deterred by the potentially uncomfortable, but likely, prospect that her contractual contingent fee might well significantly exceed the plaintiff's actual recovery.

Inc. v. AmClyde, 511 U.S. 202, 215 (1994) ("public policy wisely encourages settlements"); *Hines v. Anchor Motor Freight, Inc.*, 424 U.S. 554, 574 (1976) (Rehnquist, C.J., dissenting) (recognizing "the consistent policy of this Court [to] encourag[e] the parties to settle their differences"). Our state and federal judicial systems would cease to function if all, or even a substantial portion, of cases were litigated to trial. *Cf.* Pet'r's Br. 29 (acknowledging that around 95 percent of all tort and medical malpractice cases are resolved prior to trial).

Yet, under N.C. Gen. Stat. § 108A-57, an injured plaintiff who has received medical treatment funded by Medicaid has little incentive to settle her personal injury lawsuit for an amount that falls far short of her total damages. Any settlement award will immediately be reduced by up to a third to reimburse the state Medicaid agency. Coupled with the plaintiff's obligation to pay attorneys' fees and litigation costs, relatively little will be left to compensate plaintiff for her injuries. Under these circumstances, a plaintiff with a substantial Medicaid reimbursement claim will have a strong incentive not to compromise her claim through settlement, but instead to "roll the dice" in hopes of obtaining a sufficient recovery through trial. *See* 547 U.S. at 288 ("a rule of absolute priority might preclude settlement in a large number of cases"). The consequence will be to impose substantially greater burdens on the legal system, while also increasing the risk of an adverse verdict that would deprive both the plaintiff and the state Medicaid agency of any recovery at all.

The explicit purpose of the third-party recovery provisions of the Medicaid Act is to reduce

Medicaid's costs. Yet, by discouraging injured Medicaid beneficiaries from pursuing injury claims and by deterring settlements, the net effect of a provision like N.C. Gen. Stat. § 108A-57 that prioritizes reimbursement to the State over compensation to the injured plaintiff may well be to reducethe overall amount of third party recoveries and therefore, perversely, to increase the Medicaid program's overall expenses. For these public policy reasons as well, this Court should adhere to its holding in *Ahlborn* and continue to require a fair and rational allocation of settlements between past medical expenses and other categories of damages.

CONCLUSION

For the foregoing reasons, *Amici* AAJ and NCAJ urge this Court to affirm the ruling of the United States Court of Appeals for the Fourth Circuit.

Date: December 17, 2012

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AMICUS CURIAE BRIEF

No. 12-98

In the Supreme Court of the United States

ALBERT A. DELIA, SECRETARY, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

E.M.A., (BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON), WILLIAM EARL ARMSTRONG, AND SANDRA ARMSTRONG,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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INTEREST OF *AMICUS CURIAE* [1]

The Federation of Defense and Corporate Counsel (the "FDCC") was formed as the Federation of Insurance Counsel in 1936. It has an international membership of approximately 1,400 lawyers. FDCC members are experienced attorneys in private practice, as well as general counsel and insurance claims executives from around the world. Membership is limited, available solely by nomination, and includes only those who have been judged by their peers to have achieved professional distinction and demonstrated leadership in their respective fields. The FDCC is committed to promoting knowledge, fellowship, and professionalism among its members.

Through its amicus curiae efforts, the FDCC seeks to assist courts in addressing issues of importance to its membership, including the issues surrounding North Carolina's Medicaid recovery statute that are involved in this case. The position advocated by Petitioner—that North Carolina may statutorily usurp up to one-third of all settlement proceeds to recoup medical expenses paid under Medicaid—has far-reaching and undesirable implications. Certainly, as described in Respondents' brief, the North Carolina statute runs afoul of the anti-lien provisions of the federal Medicaid Act and this Court's decision in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006). The FDCC, however, finds Petitioner's stance troubling for additional rea-

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[1] No counsel for a party authored this brief in whole or in part. No person or entity other than the FDCC, its counsel, or its members, made any monetary contribution toward preparation or submission of this brief. (Rule 37.6.) Letters indicating the parties' consent to the filing of this brief have been submitted to the Clerk. (Rule 37.3.)

sons. Not only is it blatantly unfair but, if adopted, Petitioner's view would: (1) have a significant chilling effect on parties' incentives to settle personal injury cases involving Medicaid; and (2) result in increased burdens on state and federal courts because fewer cases would settle in their early stages.

Because of the impact on settlement motivations, this case affects the interests of all litigants and potential litigants in personal injury cases. The FDCC is committed to safeguarding the rights of defendants and ensuring that state laws are construed fairly and not in a way that dissuades parties from resolving their differences. Notably, the issues involved in this case are somewhat unique in that they bridge the ideological divide that often separates plaintiffs and defendants; indeed, all litigants can agree that settlement incentives are an important consideration and should be preserved. Accordingly, the FDCC supports the position of Respondents, who were the plaintiffs before the trial court.

STATEMENT OF THE CASE

In *Ahlborn*, this Court considered the function of the anti-lien provision of the federal Medicaid Act as it relates to a state's efforts to recoup its Medicaid costs. *See Ahlborn*, 547 U.S. at 272. Specifically, the issue before the Court was whether a state may impose a lien on property belonging to a Medicaid recipient when the state's Medicaid costs exceed what the recipient recovered as compensation for medical expenses. *See id.* This Court held that the Medicaid Act precludes such liens. *Id.* States may recover Medicaid expenditures from damages a Medicaid re-

cipient receives from a third-party tortfeasor—but only to the extent those damages represent compensation for medical expenses. *See id.* at 284-85.

Ahlborn does not establish a mechanism by which damages are to be allocated between compensation for medical expenses and compensation for other aspects of a claimant's injury (pain and suffering, or lost wages, as examples). Certainly, the parties are best situated to know how, why, and for what reasons a Medicaid recipient is compensated for his/her injuries. Instead of allowing the litigants to participate in the allocation of damages, though, North Carolina has declared by statute that one-third of any verdict or settlement received by a Medicaid recipient constitutes compensation for medical expenses and is subject to recovery. *See* N.C. GEN. STAT. §§ 108A-57, 108A-59. Throughout its brief, Petitioner refers to the one-third assessment as a "calculation" or "formula." Petitioner's description is a misnomer that does not adequately convey the arbitrary nature of North Carolina's take. The statute creates an irrebuttable one-third allocation that just as easily could have been set at one-half, or two-thirds, or any other amount that satisfied the General Assembly's whim. In short, the statute ignores what the parties (and in cases that go to trial, the jury) actually determined was appropriate compensation for medical expenses.

For these and other reasons, the Fourth Circuit concluded that North Carolina's statutory allocation was preempted by the federal Medicaid Act. *E.M.A. v. Cansler*, 674 F.3d 290 (4th Cir. 2012). This Court granted certiorari. As explained below, and in Respondents' brief, the Fourth Circuit should be affirmed.

SUMMARY OF ARGUMENT

Under Petitioner's interpretation of North Carolina's Medicaid recovery statute, one-third of any settlement or verdict is subject to being taken by the state regardless of whether the recovery was paid as compensation for medical expenses. As noted above, Petitioner's view, if adopted, would violate the federal Medicaid Act and this Court's decision in *Ahlborn*. The FDCC finds Petitioner's stance disconcerting for other reasons as well: (1) it is patently and inherently unfair; (2) reversing the Fourth Circuit would have a negative impact on parties' incentives to settle; and (3) the imposed reluctance to settle would result in increased burdens on our court system.

Petitioner's view unjustly allows the state to take a significant share of the total recovery without any regard for the level of compensation received for medical expenses. Moreover, it does so by statutory proclamation, leaving the injured party to bear all of the costs of recovery. The state is free to exercise its right of subrogation, in which case it would bear the expense of its recovery. Instead, under Petitioner's scheme, the state can sit back, allow the injured party to do all of the recovery work, and then seize its arbitrary share.

This inequitable procedure would lead to further disruptive consequences. When coupled with the contingency fee normally required to pay the injured party's counsel, under Petitioner's view, an injured party would see his/her recovery reduced by more than sixty-six percent (or more, depending on the percentage of the attorney's contingency fee) before

realizing a single dime. Accordingly, under this scheme, injured parties would need to insist on increased compensation before being willing to settle. In other words, they would need to demand higher settlements to offset the state's one-third assessment, so that their net recovery would reasonably compensate them for their injuries. For their part, defendants surely would not volunteer to bear the cost of the state's one-third Medicaid assessment and would only be willing to pay what they believe to be a reasonable value of the claim. As the injured party's demands and the defendant's offers grow farther apart, fewer and fewer litigants will be able to identify common ground on which to settle.

With fewer cases settling, the number of lawsuits pending before courts, whose resources already are strained, will grow. Among other problems, an increased caseload would increase the time it takes cases to reach resolution and otherwise slow the administration of justice. For these reasons, which Petitioner largely ignores, the Fourth Circuit's decision should be affirmed.

ARGUMENT

I. Petitioner's Position Is Patently and Inherently Unfair

Under Petitioner's view of the law, the state is entitled to take up to one-third of an injured party's recovery to recoup medical expenses paid under Medicaid regardless of the amount of compensation actually received for medical expenses. This Court already has determined that a state can exercise a lien only over funds paid as compensation for medical ex-

penses. *Ahlborn*, 547 U.S. at 284-85. In other words, a state cannot impose a lien and seek to take funds paid as compensation for pain and suffering, or any other aspect of damages besides medical expenses. To facilitate its end-run around the Court's holding in *Ahlborn*, Petitioner reads the North Carolina Medicaid recovery statute as a proper allocation of compensation for medical expenses. It is not.

Petitioner's reading is misguided and flatly unfair for at least two reasons. First, in the face of *Ahlborn*, it wholly ignores the actual compensation received by the injured party for medical expenses. Whether an allocation is determined by the parties or a jury (or not determined at all), the state has imposed by fiat its one-third medical expenses allocation in all cases involving Medicaid.

Cases such as the one presently before the Court illustrate the blatant unfairness of Petitioner's view. Here, the injured party, a minor, suffered permanent life-altering injuries. Because there was limited insurance available, and a defendant who was not fully solvent, the injured party was forced to settle for what was available. The entirety of her settlement reasonably and justifiably could have been allocated by the superior court judge to pain and suffering without her being made whole. Under Petitioner's view of the statute, though, the state is empowered to swoop in and seize one-third of the full amount received, further depleting the injured party's already insufficient recovery and exacerbating the inadequacy of the compensation received for her injuries. The state should be required to respect, or to at least consider, the actual compensation received for medi-

cal expenses so that its lien is not disproportionate to the total compensation provided to the injured party.

Petitioner's view is patently unjust for another reason. The mechanism of recovery utilized by the state is an absolute power-play that shifts the entire burden of recovery to the injured party. In appropriate cases, the state has a right of subrogation for expenses paid under Medicaid. The state is free to exercise its right of subrogation, and pursue on its own a recovery of healthcare expenses paid on account of another's tortious acts. If the state were to follow that route, it would incur and bear the expenses associated with its recovery (time, resources, attorneys' fees, and costs, among other expenses). It would also bear the risk associated with recovery efforts. Under Petitioner's view, though, the state does not have to bear any cost or risk. Instead, it can sit back and wait for the money to appear, while the injured party bears all of the cost and risk associated with obtaining a recovery. If the injured party is successful, the state can then seize its presumptive share free and clear, without risk. It is unreasonable for the state to shift the costs and risks associated with recovery to the plaintiff and, at the same time, ignore the extent to which the plaintiff is actually compensated for his/her medical expenses.

The inequities of Petitioner's position, if adopted, also would prove disruptive to our legal system. Particularly worrisome are the undesirable impact the state's presumptive lien would have on settlement prospects in cases involving Medicaid and the resulting increased burden on our court system. If the Fourth Circuit is overturned, as Petitioner urges, these undesirable outcomes could become reality.

II. If Adopted, Petitioner's Position Would Strongly Dissuade Settlement in Tort Cases Involving Medicaid

As Petitioner notes, under North Carolina's statutory scheme, the Medicaid recipient's lawyer is charged with enforcing the state's lien against proceeds received from a third-party tortfeasor as compensation for medical expenses. (Pet.'s Br. at 24.) According to Petitioner, at the time of settlement discussions, the recipient's lawyer can (and should) notify all parties of the amount of medical expenses paid so that the state's lien can factor into the parties' settlement evaluations. (*Id.*) Because the lien amount is statutorily prescribed at one-third of the settlement proceeds, Petitioner argues, all parties will know in advance what impact the lien will have on any settlement payment and will negotiate accordingly. (*Id.*) Petitioner views this feature of North Carolina's statutory scheme as a positive development that benefits all parties in litigation. (*See generally id.* (highlighting the purported benefits of North Carolina's statute).) Petitioner's stance is naive, and ignores the realities of adversarial litigation.

A. Petitioner Ignores the Realities of Settlement Motivations

Numerous courts have observed that the vast majority of cases are resolved through settlement. *See, e.g., Pratt v. Philbrook*, 109 F.3d 18, 20 n.4 (1st Cir. 1997) (discussing the role of courts in encouraging settlements); *Bell, Boyd, & Lloyd v. Tapy*, 896 F.2d 1101, 1103 (7th Cir. 1990) (noting that most case settle to avoid the costs of trial); *Delaventura v. Colum-*

bia Acorn Trust, 417 F. Supp. 2d 147, 150-52 (D. Mass. 2006) (noting that most cases settle and discussing that federal MDL procedures are designed to encourage settlement). The judiciary's limited resources make settlement a speedier alternative in many cases. Moreover, settlements are overtly encouraged through court-sponsored mediation programs, which are now mandatory in many jurisdictions. These (and other) factors contribute to the current litigation landscape, in which the majority of all cases filed are resolved through settlement, with only a fraction of cases proceeding to trial. For example, of the 218,316 civil cases filed in North Carolina's district and superior courts from July 1, 2011 through June 30, 2012, only 463—or, less than one percent—were determined by a jury. *See* NORTH CAROLINA COURTS STATISTICAL AND OPERATIONAL REPORT, TRIAL COURTS (July 1, 2011 – June 30, 2012).[2]

Because so many cases settle, the impact that laws have on settlement incentives is a paramount consideration that should not be overlooked. Petitioner's view of North Carolina's Medicaid recovery statute, however, would have a lasting negative impact on parties' settlement motivations. For example, certainty and cost savings are two primary reasons parties choose to settle instead of taking cases to trial. Parties gain certainty because they know and control what they will pay or receive in settlement; costs come into play because parties can avoid much of the expense of litigation by resolving their differences early. As explained below, both of these set-

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[2] Available at <www.nccourts.org/Citizens/SRPlanning/Documents/2011-12_SOR-TrialCourts.pdf>.

tlement drivers would be significantly diminished under Petitioner's application of the law.

1. North Carolina's Presumptive Statutory Lien Is Especially Probelmatic in Contingency Fee Cases

The vast majority of personal injury cases—including those filed by or on behalf of Medicaid recipients—are brought by counsel under a contingency fee arrangement. In other words, the Medicaid recipient's lawyer will be compensated for his/her services with a percentage of the proceeds of the litigation. Common contingencies range from one-third to forty percent of the verdict or settlement amount.[3] Most Medicaid recipients, therefore, have to use at least one-third of their recovery to pay for the legal services that enabled them to obtain compensation for their injuries.

Petitioner contends, however, that another one-third of the Medicaid recipient's recovery should be paid to North Carolina, regardless of how the recovery is structured and regardless of the extent to which the recovery is intended to compensate for medical expenses. Under Petitioner's view, then, the Medicaid recipient—the injured party—will never see two-thirds (or more) of his/her compensation. Importantly, Petitioner would reduce the injured party's recovery by two-thirds even if only a small portion of the settlement or verdict was intended as compensation for medical expenses.[4]

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[3] In some instances, particularly in the event of a trial or when a verdict is appealed, the contingency fee can be even higher.

[4] Often, because of the prevalent use of general verdicts, the parties cannot know with any certainty how a jury allocated or

Because such a large segment is consumed by legal fees and the state's statutory assessment, injured parties will have little choice but to insist on higher compensation before agreeing to compromise their claims. If there were no lien imposed by the state, a Medicaid recipient who subjectively and reasonably believes that $100,000 net would be fair compensation could settle his/her case for $150,000. One-third ($50,000) could be used to pay the injured party's lawyer, and the remaining $100,000 would fairly compensate the injured party. When the state's irrebuttable one-third lien is injected into the equation, however, the same injured party would have to demand $300,000 to realize the same level of compensation (one-third, or $100,000, to the recipient's lawyer and another one-third, or $100,000, to satisfy the lien). In other words, under this example, the injured party's settlement target is doubled, from $150,000 to $300,000, simply because of the existence of the statutory lien.

Certainly other examples using different numbers would yield different results. The analogy, however, is valid; under Petitioner's view of the law, Medicaid recipients will have to demand significantly more money in settlement in order to realize an amount

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calculated damages. Petitioner's argument seems to be that even in cases when a special verdict form is used, and a jury separately compensates the injured party for each aspect of his/her claim for damages, the one-third lien still is triggered. This position is troubling, as it usurps the role of the jury in determining damages, demonstrates the arbitrary nature of decreeing one-third as the lien amount, and directly disobeys this Court's holding in *Ahlborn* that only compensation for medical expenses is subject to recovery by the state. *See, e.g., Ahlborn*, 547 U.S. at 284-85.

that approaches what they believe is fair compensation for their injuries. Contrary to the rosy picture painted by Petitioner, this outcome would not represent a positive development in the law.

2. Higher Settlement Demands Necessarily Would Adversely Impact Settlement Prospects

Unfortunately, the negative consequences of Petitioner's application of the law do not simply end with higher settlement demands. Increased settlement demands will not, *ipso facto*, translate into higher settlements. Indeed, as injured parties are compelled to seek higher recoveries, settlement demands will more consistently fall outside the range of what defendants are willing to pay to avoid the risks associated with going to trial. Although this phenomenon is true in all cases, it will be particularly noticeable in cases when medical expenses did not play a significant role in the settlement discussion and are not a key feature of the compensation paid. As a natural consequence of having higher settlement demands, fewer cases will settle. *See generally* Stephen Bundy, *The Policy in Favor of Settlement in an Adversary System*, 44 HASTINGS L.J. 1, 13-15 (1992) (discussing settlement incentives and the claim value range in which both parties benefit from settlement).

As noted above, two of the primary drivers of settlement discussions are certainty and cost avoidance. Parties obtain certainty through settlement because they can control what they pay/receive in settlement, and they can avoid the unpredictability that is inherent in jury trials. Parties can avoid costs through settlement by resolving their difference before too much time and too many resources are directed at

discovery and trial; the sooner they settle, the more they can save. As the cost of settlement increases, however, these settlement motivations will become less and less attractive. In short, the relative cost of settlement will no longer compare as favorably to the cost of continued litigation. Once the cost savings associated with settlement diminishes (or vanishes outright), litigants will be less concerned with avoiding the uncertainty of juries and will be more willing to roll the dice in hopes of a positive outcome at trial.

To reiterate, the FDCC's concerns are not exaggerated and are not merely hypothetical. The existence of an irrebuttable one-third statutory lien would have a negative impact on settlement discussions. As shown above, the one-third lien can as much as double the target settlement amount required to fairly compensate an injured party for his/her injuries. To the extent North Carolina is entitled to seek recovery of amounts paid under Medicaid, it should be a matter of seeking actual medical expenses paid from actual compensation received for medical expenses.[5]

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[5] Although not directly addressed by the parties, the plain language of the federal Medicaid Act's anti-lien provision seems to preclude the existence of any state-asserted lien. *See* 42 U.S.C. § 1396p(a)(1). The Medicaid Act provides: "No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf" except (1) pursuant to the judgment of a court on account of benefits incorrectly paid or (2) in the case of real property belonging to the individual if certain specified conditions are met. *Id.* Here, there is no allegation of incorrectly paid benefits and the injured party, E.M.A., is a minor who owns no real property. Therefore, under a plain reading of the Medicaid Act, a lien in favor of North Carolina should not arise in any event.

Applying the law in any other way—and particularly imposing an irrebuttable one-third lien on the Medicaid recipient's full recovery regardless of the amount of compensation actually received for medical expenses—is untenable and inconsistent with this Court's directives in *Ahlborn*. If a lien must arise, it should be commensurate with the compensation actually received for medical expenses. If that were the case, the parties would be free to negotiate a settlement to resolve their differences without having to consider the weight of an automatic one-third assessment. Then, if appropriate, the Medicaid recipient would be free to negotiate with the state to determine the proper scope of the state's recovery.

B. Petitioner Ignores the Realities of How Damages Claims Are Evaluated

Petitioner claims throughout its brief that the one-third statutory lien is necessary to eliminate the incentive for litigants to avoid the state's lien by allocating most or all of the plaintiff's recovery to damages categories other than medical expenses. (*See* Pet.'s Br. at 30-33 (discussing the need for an automatic and unyielding lien to keep parties from allocating away the state's interest).) While Petitioner's argument may appear to have some simplistic appeal, it ignores the reality of how damages typically are evaluated for purposes of settlement.

Curiously, the National Governors Association and others who provided *amici curiae* support to Petitioner do not agree with North Carolina's reading of its own statute.[6] According to the National Gover-

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[6] Joining the National Governors Association in a single *amici curiae* brief were the National Conference of State Legislatures,

nors Association's brief, North Carolina's statute, when read in conjunction with *Ahlborn*, encourages parties to allocate their settlements among the various aspects of damages, (*see* Nat'l Gov. Assoc. Br. at 9-11), something that Petitioner says cannot occur, (*see* Pet.'s Br. at 25-26). More specifically, the National Governor's Association affirmatively states that parties can avoid the one-third lien by allocating a specific portion of the damages recovery to medical expenses. (*Id.* at 10-11 ("*Ahlborn* . . . give[s] a Medicaid recipient a clear method for delineating the State's entitlement: specify the allocation in the settlement agreement."); *see also id.* at 4 (stating that the one-third lien is "avoidable" if the parties would specify a reasonable damages allocation in their settlement agreement).) According to the National Governors Association, if the parties specify a portion of damages as compensation for medical expenses, as long as the allocation is reasonable, the state will be bound by it. (*See id.* at 4, 10-11.)

Petitioner, of course, takes a very different stance in its brief. According to Petitioner, the state is not bound by the parties' allocation; it can utilize the one-third lien to recover its take notwithstanding the amount of compensation that may have been designated by the parties as compensation for medical expenses. (*See* Pet.'s Br. at 14-15, 25-26 ("Irrespective of whether the parties to a settlement purport to 'designate' the amount of the medicals or not, the Medi-

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the Council of State Governments, the National Association of Counties, the International City/County Management Association, the National League of Cities, the United States Conference of Mayors, the Government Finance Officers Association, and the City of New York.

caid lien is protected since it is established and defined by statute.").) In other words the very basis under which the National Governors Association found the North Carolina recovery statute consistent with *Ahlborn* is flatly undermined by Petitioner's opposite and unsupportable stance. As even the National Governors Association makes clear, without any ability for the parties to specify an appropriate and reasonable damages allocation, the North Carolina statute cannot be reconciled with *Ahlborn* because there is no way to ensure that the lien is representative of actual compensation for medical expenses. Petitioner's disregard for allocations by the parties, even if those allocations are reasonable, confirms that Petitioner is concerned not with accuracy, fairness, or following the law, but rather, with recovering as much money as it can, regardless of the consequences to the injured party or to the legal system.

Petitioner's proposed treatment of damages also is shortsighted for another reason—it fails to account for the fact that not all medical expenses claimed in personal injury litigation resulted from the actions of the tortfeasor. In many cases, the injured party suffers from pre-existing medical conditions; sometimes the incident that prompts a lawsuit aggravates a pre-existing condition; other times it does not. In any event, defendants often look for evidence of pre-existing medical conditions to counter the injured party's claims. Such evidence can show that the plaintiff would have experienced pain anyway, and in some cases, that the plaintiff was already injured at the time of the incident at issue in the lawsuit. When the validity of claimed medical expenses is called into question with evidence of a pre-existing condition, the settlement value of the plaintiff's claim necessarily is

diminished. Often, the amount of medical expenses the defendant is willing to cover or factor into its valuation of the case is thereby reduced, and this reduction is reflected in a concomitant reduction of the plaintiff's total recovery.

There is no room under Petitioner's theory, however, for this type of analysis. The state can acquire one-third of the plaintiff's total recovery regardless of the validity of the medical expenses involved in the case and regardless of what steps the defendant has taken to expose weaknesses in the plaintiff's claim for medical expenses. There is no start date or end date for medical expenses and, more importantly, no tracing of the expenses actually and ultimately at issue in a plaintiff's cause of action. Instead, the state categorically claims entitlement to one-third of the recovery without regard to the true nature of the recoverable expenses. Allowing the parties to allocate categories of damages, or to determine damages through some other adversarial process, would improve accuracy by ensuring that only damages actually caused by the tortfeasor are subject to recovery by the state. Unfortunately, these methods are not permitted under North Carolina's statute.

III. If Adopted, Petitioner's Position Would Result in Increased Burdens on Our Court System

As described above, the position advanced by Petitioner, if adopted, would neutralize settlement incentives, resulting in fewer settlements. Fewer cases settling necessarily would mean more cases pending. The obvious and unavoidable consequence would be a

noticeable increase in the burden on our court system.

As already explained, almost all cases are resolved in some manner prior to trial. Court-sponsored mediation programs offer a good demonstration of how effective settlement is at reducing the caseload of our judiciary. For example, on July 1, 2011, there were approximately 9,931 civil cases pending in North Carolina's superior court system. *See* NORTH CAROLINA COURTS MEDIATED SETTLEMENT CONFERENCE (MSC) STATISTICAL REPORT (July 1, 2011 – June 30, 2012).[7] By June 30, 2012, 2,813 of those pending cases were resolved through court-mandated mediated settlement conferences. (*Id.*) Another 1,967 cases were reported settled prior to or during a recess in the mediated settlement conferences. (*Id.*) In other words, North Carolina's mandatory mediation program had a hand in resolving 4,780 of the 9,931 cases that were pending on July 1, 2011. These figures represent a mediation success rate of almost fifty percent.[8] (*See id.*)

With settlement figures like these, it is apparent that North Carolina (as well as all other states) is heavily dependent on court-mandated mediation programs to manage caseloads and ensure efficient administration of justice. While Petitioner's position would not prevent all cases from settling, the FDCC expects it would result in a very significant and noticeable reduction in the frequency of settlement.

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[7] Available at <www.nccourts.org/Courts/CRS/Councils/DRC/Documents/msc_stats11-12.pdf>.

[8] Notably, these figures do not account for the numerous cases that settle after mediation has ended at an impasse.

Reduced settlement rates would soon translate into significant increased burdens on our court systems. These burdens would tax the resources of our court system and slow the administration of justice. The FDCC urges the Court to affirm the Fourth Circuit's decision in order to prevent such an untenable result.

* * *

Petitioner's view of North Carolina's Medicaid recovery statute is inconsistent with the federal Medicaid Act and this Court's opinion in *Ahlborn*. Petitioner believes that the state is entitled to seize one-third of a Medicaid recipient's tort recovery regardless of what portion of that recovery represents compensation for medical expenses. This view is unfair and violates the law. Moreover, it would significantly diminish settlement prospects in personal injury cases involving Medicaid and increase the already substantial burden on our court system. The decision of the Fourth Circuit adequately protects North Carolina's interest while ensuring that the portion of the recipient's settlement or verdict that is subject to recovery is tied to actual recovery for medical expenses. The Fourth Circuit should be affirmed.

CONCLUSION

For the foregoing reasons, the decision of the Fourth Circuit should be affirmed.

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AMICUS CURIAE BRIEF

RECORD AND BRIEFS

No. 12-98

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IN THE

Supreme Court of the United States

ALBERT A. DELIA, SECRETARY, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

E. M. A., A MINOR, BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON, WILLIAM EARL ARMSTRONG, AND SANDRA ARMSTRONG,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF FOR THE NATIONAL GOVERNORS ASSOCIATION, NATIONAL CONFERENCE OF STATE LEGISLATURES, COUNCIL OF STATE GOVERMENTS, NATIONAL ASSOCIATION OF COUNTIES, INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION, NATIONAL LEAGUE OF CITIES, UNTED STATES CONFERENCE OF MAYORS, GOVERNMENT FINANCE OFFICERS ASSOCIATION, AND CITY OF NEW YORK AS *AMICI CURIAE* SUPPORTING PETITIONER

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INTEREST OF *AMICI CURIAE* [1]

The National Governors Association (NGA), founded in 1908, is the collective voice of the Nation's governors. NGA's members are the governors of the 50 States, three Territories, and two Commonwealths.

The National Conference of State Legislatures (NCSL) is a bipartisan organization that serves the legislators and staffs of the nation's 50 States, its Commonwealths, and Territories. NCSL provides research, technical assistance, and opportunities for policymakers to exchange ideas on the most pressing state issues. NCSL advocates for the interests of state governments before Congress and federal agencies, and regularly submits *amicus* briefs to this Court in cases, like this one, that raise issues of vital state concern.

The Council of State Governments (CSG) is the Nation's only organization serving all three branches of state government. CSG is a region-based forum that fosters the exchange of insights and ideas to help state officials shape public policy. This offers unparalleled regional, national, and international opportunities to network, develop leaders, collaborate, and create problem-solving partnerships.

The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. NACo provides

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[1] The parties have consented to the filing of this brief, and their letters of consent are on file with the Clerk (Rule 37.2). This brief was not written in whole or in part by the parties' counsel, and no one other than the *amicus* made a monetary contribution to its preparation (Rule 37.6).

essential services to the Nation's 3,068 counties through advocacy, education, and research.

The International City/County Management Association (ICMA) is a nonprofit professional and educational organization of over 9,000 appointed chief executives and assistants serving cities, counties, towns, and regional entities. ICMA's mission is to create excellence in local governance by advocating and developing the professional management of local governments throughout the world.

The National League of Cities (NLC), founded in 1924, is the oldest and largest organization representing municipal governments throughout the United States. Working in partnership with 49 state municipal leagues, NLC serves as a national advocate for the more than 19,000 cities, villages, and towns it represents. Its mission is to strengthen and promote cities as centers of opportunity, leadership, and governance.

The U. S. Conference of Mayors (USCM), founded in 1932, is the official nonpartisan organization of all United States cities with a population of more than 30,000 people, which includes over 1,200 cities at present. Each city is represented in the USCM by its chief elected official, the mayor.

Government Finance Officers Association (GFOA) is the professional association of state, provincial, and local finance officers in the United States and Canada. The GFOA has served the public finance profession since 1906 and continues to provide leadership to government finance professionals through research, education, and the identification and promotion of best practices. Its 17,500 members are

dedicated to the sound management of government financial resources.

The City of New York (NYC) is a municipal corporation in New York State. Under New York State law, NYC administers the Medicaid program and is financially responsible for 25 percent of nearly all Medicaid costs for its residents. NYC ranks third in Medicaid spending in the United States after New York State and the State of California.

These groups submit this brief as *amici curiae* because their members will be directly affected by the Court's decision in this case. Through Medicaid, *amici*'s members fund necessary health care for their poorest inhabitants at this time of historic pressure on State and local resources. *Amici* support the petitioner in this case because, as this brief explains, North Carolina's Medicaid recovery statute, as construed by the North Carolina Supreme Court, provides an efficient, fair, and reasonable method for States to recover costs imposed on State budgets by tortfeasors.

STATEMENT OF THE CASE

Amici rely on the statement of the case set forth in the petitioner's brief.

SUMMARY OF ARGUMENT

Through their Medicaid programs, the States pay out enormous portions of their budgets to provide medical care to their neediest residents, and those costs are spiraling upward at an increasing rate. Reimbursement from third-party tortfeasors who have wrongly forced the State to incur even higher Medicaid expenses is one of the few ways that States

can defray their costs. Medicaid leaves considerable discretion to the States in implementing its requirements, including as to how to economically seek such third-party reimbursement.

When a Medicaid recipient settles a claim against a tortfeasor, the State is entitled, and often is required, to recoup its expenses. As construed by the North Carolina Supreme Court, North Carolina law limits the State's recovery to the amount that the recipient and the tortfeasor agree in good faith should be allocated to medical expenses. But in the situation presented here, where the parties failed to exercise their option to expressly allocate their settlement, North Carolina law provides a default recovery of one-third of the settlement or the full amount of the State's expenditure, whichever is less. That is a reasonable way, in that limited and avoidable situation, for the State to avoid the costs of interposing itself in settlement talks or participating in a mini-trial, after the fact, on the question of what might be a proper allocation. And it makes perfect sense as a matter of law, for under common law contract principles applied in North Carolina, and in the absence of some other express allocation, the parties' settlement agreement simply incorporates the default one-third allocation provided by the North Carolina statute.

North Carolina's statute is further reasonable because it takes a relatively generous approach to third-party reimbursement. It leaves the Medicaid recipient with two-thirds of any recovery even when the State has spent far more than that paying for that recipient's medical care. And this generous approach has been specifically approved as consistent with federal law by the federal agency that admin-

isters Medicaid, an interpretation of the federal Medicaid statute to which this Court should defer. For these reasons, the North Carolina statute should be upheld, and the Fourth Circuit's decision should be reversed.

ARGUMENT

I. STATES HAVE, AND REQUIRE, SUBSTANTIAL DISCRETION IN IMPLEMENTING MEDICAID

A. States face constant, increasing budgetary pressure, and require latitude in seeking Medicaid reimbursement

As with all healthcare costs in the United States, the costs to States of providing medical care to their poorest citizens through Medicaid have been increasing for decades. These costs have grown significantly faster than the national economy, and faster than tax revenue. CENTERS FOR MEDICARE & MEDICAID SERVICES, OFFICE OF THE ACTUARY, 2011 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID ii (Mar. 16, 2012) [hereinafter 2011 ACTUARIAL REPORT]. From 1970 to 2010, combined federal and state Medicaid expenditures have quintupled from 0.5 percent of the United States' gross domestic product to 2.7 percent. *Id.* The recent economic downturn—the nation's deepest recession since the Great Depression—has driven Medicaid costs higher even more sharply.

As economic conditions have deteriorated and Americans have lost jobs and health insurance, the States' Medicaid programs have stepped in to fill coverage gaps. Medicaid enrollment and resulting federal and state expenditures have skyrocketed. In

2009 alone, Medicaid expenditures nationwide increased by 7.6 percent and enrollment grew by an estimated 6.5 percent. *Id.* at 17. Between 2000 and 2009 (the most recent date for which data is available), the number of Medicaid beneficiaries in North Carolina grew from 1.2 million to 1.8 million people. U. S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2012, TABLE 152, MEDICAID – SUMMARY BY STATE: 2000 TO 2009 (2012). As a result, North Carolina's Medicaid disbursements nearly doubled from $4.8 billion to $9.6 billion. *Id.* These surges in Medicaid enrollment and expenditures show no signs of abating. The U.S. Department of Health and Human Services estimates expenditures will increase at an average annual rate of 8.1 percent and reach $871 billion by 2020. 2011 ACTUARIAL REPORT, at iv.

Simultaneously, the States' revenue sources to cover Medicaid and other expenditures have been shrinking. The majority of State expenses are paid for with funds from personal income taxes, sales taxes, and corporate income taxes. MARTHA HEBERLEIN & JOAN ALKER, STATE BUDGET WOES: REVENUE DECLINES, NOT MEDICAID SPENDING, ARE TO BLAME 1 (Mar. 2012). These taxes are directly affected by the overall health of the economy, and have steadily decreased in the past several years as the employment rolls have contracted and as personal income has declined. *Id.* at 2. By the second quarter of 2009, "income tax collections were 27% below their level one year earlier and total state taxes were 17% lower" while "spending demand continued or escalated, particularly for Medicaid." KAISER COMMISSION ON MEDICAID AND THE UNINSURED, UPDATE: STATE BUDGETS IN RECESSION AND RECOVERY 1 (2011). In

North Carolina, the State's $9.6 billion in Medicaid expenditures in 2009 were nearly 50 percent of general fund revenues for that year. *See* NORTH CAROLINA DEP'T OF REVENUE, STATISTICAL ABSTRACT OF NORTH CAROLINA TAXES 2011, PART II, SUMMARY OF STATE GENERAL FUND REVENUE COLLECTIONS, TABLE 2, STATE GENERAL FUND: TAX REVENUES BY SOURCE (2012). Even if the economy improves and tax revenues increase, in 2014 many States will begin participating in the Patient Protection and Affordable Care Act's Medicaid expansion, which will significantly increase Medicaid participation and expenditures. The expansion will be totally funded by the federal government only through 2016. *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2,566, 2,601 (2012).

B. The Medicaid statute gives States the latitude they need to accomplish Medicaid's ends

In light of these fiscal pressures, it is vital that States have every option open to them to defray the costs of Medicaid. And the Medicaid statute in fact grants States substantial discretion in implementing Medicaid generally and in pursuing recovery from third-party tortfeasors in particular.

While the federal government contributes substantially to Medicaid, the States bear up to 50 percent of the costs, including the recent increases. *See, e.g.*, Federal Financial Participation in State Assistance Expenditures, 75 Fed. Reg. 69,082, 69,083 (Nov. 10, 2010) (setting federal medical assistance percentages). The States take the federal government's Medicaid funds subject to the conditions that Congress has imposed, but the "Medicaid statute is de-

signed to advance cooperative federalism." *Wisconsin Department of Health & Family Services v. Blumer*, 534 U. S. 473, 495 (2002). Consistent with their responsibility to pay out a large share of the costs of Medicaid, and with the duty that they have assumed to serve, *parens patriae*, as the health insurer of last resort for those in need, the States have broad discretion in designing and implementing their Medicaid programs.

States are responsible, for example, for deciding the most basic terms of Medicaid services: who will be eligible for Medicaid; what services they may receive; the rates for services; and the standards to which providers are held. *See* 42 U. S. C. §§ 1396a(a)(5), (9). As this Court has observed, the federal Medicaid statute "confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act." *Beal v. Doe*, 432 U. S. 438, 444 (1977); *see also, e.g.*, *Alexander v. Choate*, 469 U. S. 287, 303 (1985) ("The Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'").

More generally, when applying a "cooperative" federal-state regime like Medicaid, this Court has "not been reluctant to leave a range of permissible choices to the States, at least where the superintending federal agency has concluded that such latitude is consistent with the statute's aims." *Blumer*, 534 U. S. at 495. One of the mandatory conditions of receiving Medicaid funding is that, as the Fourth Circuit observed, "states participating in the Medi-

caid program" must "seek reimbursement from third-party tortfeasors for health care expenditures made on behalf of Medicaid beneficiaries who are tort victims." Pet. App. 2a; *see* 42 U. S. C. § 1396a(a)(25). States are required to make "all reasonable efforts" to ascertain the liability of third parties for expenses paid by Medicaid, and are further required to enact laws providing that "to the extent" that Medicaid has paid medical assistance to an individual, "the State is considered to have acquired the rights of such individual to payment by any other party" to reimburse the State for that assistance. 42 U. S. C. §§ 1396a(a)(25)(A), (H). But here again, and importantly in this case, the methods for ascertaining liability and obtaining reimbursement are generally left to the States.

II. NORTH CAROLINA'S REIMBURSEMENT REGIME IS A REASONABLE EXERCISE OF DISCRETION

A. North Carolina reasonably allocates settlements when the parties have declined to allocate—and encourages allocation

To implement the requirement that States seek reimbursement from tortfeasors, North Carolina law provides that a Medicaid recipient's right to recover medical expenses from a third-party tortfeasor belongs to the State. N. C. GEN. STAT. § 108A-59 (2012). It also provides that, where a Medicaid recipient brings an action against a third-party tortfeasor and the action concludes through a judgment or settlement, the recipient's attorney is bound to, "out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from

a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary," but that "the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered." N. C. GEN. STAT. § 108A-57 (2012). The State's recovery is thus the lesser of one-third of the total amount of recovery, or all of the State's medical expenses. *Id.*

In *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U. S. 268 (2006), this Court held that "[t]here is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care" but "that does not mean that the State can force an assignment of, or place a lien on, any other portion of [a Medicaid recipient's] property." *Id.* at 284. In *Ahlborn*, unlike here, the parties had all expressly agreed on a portion of the settlement that related to medical care. This Court held that the State could not recover more than that agreed upon amount.

The Supreme Court of North Carolina subsequently held that "*Ahlborn* * * * controls when there has been a prior determination or stipulation as to the medical expense portion of a plaintiff's settlement. In those cases, the State may not receive reimbursement in excess of the portion so designated." *Andrews ex rel. Andrews v. Haygood*, 669 S.E.2d 301, 313 (N.C. 2008).[2] *Ahlborn* and *Andrews*

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[2] *Amici* assume that a manipulated stipulation, in which a tortfeasor and a Medicaid recipient agree in bad faith to allocate an unreasonably small portion of a settlement to medical expenses in order to thwart a State's right of recovery, would not be entitled to this kind of controlling weight even under

thus give a Medicaid recipient a clear method for delineating the State's entitlement: specify the allocation in the settlement agreement.

In this case, the settlement agreement, which is between the individual for whom the State paid medical expenses and the party who is accused of causing the harm, does not specify that any portion of the settlement amount was intended to cover non-medical expenses, and does not specify a portion that was intended solely as reimbursement for medical expenses. *See* Pet. App. 3a ("The settlement agreement did not allocate separate amounts for past medical expenses and other damages."). Consequently, the only question that the Court has to answer in this case is whether a State may recover under a statutory allocation scheme like North Carolina's in those narrow circumstances where the parties settle a tort dispute, but fail to specify any allocation for medical expenses.

As in any circumstance in which a State has discretion to choose the means to accomplish a statutory end, there are several options. Two potential options for dealing with the non-allocation scenario, suggested by the Fourth Circuit, are: (1) State participation in the settlement; and (2) a post-settlement hearing to determine the State's share. Both are impractical and impair the ends of Medicaid, have been rejected by North Carolina, and should be rejected by this Court.

First, the State could participate in settlement discussions involving Medicaid recipients. The purpose would be for the State to agree in advance to the

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Ahlborn. That issue is not before the Court in this case and ought not be addressed on these facts.

apportionment of any settlement, or withhold consent to any settlement that failed to protect the State's right to recover. Requiring this approach would be a significant burden on the State. The costs of sending a representative to every settlement conference in which a State recovery might be at issue would be prohibitive. Indeed, the Medicaid statute requires the State to seek recovery only when the benefits of seeking recovery are likely to outweigh the costs of pursuing it. 42 U. S. C. § 1396a(a)(25)(H). Settlement negotiations are inherently speculative; there is no guarantee that a settlement will be reached or that any recovery will be forthcoming. So there is a guaranteed waste of resources built into such a regime. That is not acceptable because spending State funds on participation in speculative settlement talks necessarily diverts funds from the ultimate goal of Medicaid: to provide medical care to the needy.

Second, the Fourth Circuit suggested that a hearing should be held, after any settlement, to determine the share that belongs to the State. This option, like the first, is wasteful. Hearings are expensive and time consuming. They would similarly divert scarce resources that could otherwise be spent providing the States' share of Medicaid coverage.

Worse, the Fourth Circuit's rule requiring a hearing where the State does not participate in the settlement may encourage parties not to allocate, and may bar State recovery as a practical matter in many cases. Parties will reasonably anticipate that the burden of holding a hearing, with an uncertain outcome, will often lead States to conclude that pursuing recovery is not cost effective. States will not pursue recovery under those circumstances. And if a State has no procedural mechanism in place for

holding such a hearing, States may simply be incapable of seeking recovery until a hearing mechanism is created by legislation.

Moreover, the proper objective of the hearing is unclear. The Fourth Circuit held that "the sum certain allocable to medical expenses must be determined, in the absence of a stipulation by the affected parties, by judicial determination or some similar adversarial process, before the state may recoup its Medicaid outlays." Pet. App. 13a. The proposal that a hearing be held supposes that the parties will have agreed to an allocation even if they have failed to memorialize it in their settlement agreement.

There is no reason to suppose that the parties will usually have agreed upon, despite failing to express, such an allocation. To the contrary, it is presumptively true that any settlement agreement will fully express what the parties actually agreed to. North Carolina law, for example, incorporates the familiar principle that "where the parties have deliberately put their engagements in writing in such terms as import a legal obligation free of uncertainty, it is presumed the writing was intended by the parties to represent all their engagements as to the elements dealt with in the writing." *Neal v. Marrone*, 79 S.E.2d 239, 242 (N.C. 1953). So in a case like this one, the fact that the parties did not set forth an allocation in their settlement means there was no allocation agreed upon. The hearing contemplated by the Fourth Circuit here would be a fishing expedition, unlikely to uncover some secret allocation existing in fact, and indeed the common law of contracts would generally deem there to have been no agreement on any such unexpressed allocation as a matter of law.

Having rejected these options, North Carolina has instead adopted the default-allocation rule that is challenged here. That rule, as noted, provides that the State may recover no more than one-third of any settlement that fails to expressly allocate a portion of the settlement to medical expenses. North Carolina's solution has significant advantages to these other options. It is efficient because it allows for the simple determination of a sum certain. It does not involve the State in speculative pre-settlement proceedings, saving scarce Medicaid resources while leaving the parties to manage their dispute without interference and thus easing the path to settlement. It also does not require a *post hoc* judicial inquiry into an allocation that likely does not exist as a matter of fact.

Perhaps most importantly, North Carolina's rule is merely a default, entirely avoidable by parties wishing to avoid it. As construed by *Andrews* in light of *Ahlborn*, North Carolina law gives the settling parties the option, in every case, to agree on an allocation for medical expenses. That allocation will bind the State and set its recovery so long as it is made in good faith. There is every reason to encourage parties to take that option.

But where the parties fail to take that option, there is no necessary tension between the North Carolina default regime and *Ahlborn*. A settlement with no express allocation simply incorporates North Carolina's default allocation as a matter of law. As this Court long ago recognized, "existing laws [are] read into contracts in order to fix obligations as between the parties." *Home Building & Loan Association v. Blaisdell*, 290 U. S. 398, 435 (1934); *see also Farmers' & Merchants' Bank of Monroe, N. C. v. Federal Reserve Bank of Richmond, Va.*, 262 U. S. 649, 660

(1923) ("Laws which subsist at the time and place of the making of a contract, and where it is to be performed, enter into and form a part of it, as fully as if they had been expressly referred to or incorporated in its terms.").

This principle is specifically true as a matter of North Carolina law: "Valid laws existing at the time and place a contract is entered into and at the place where it is to be performed, are read into and become a part of a contract unless a clear intent to the contrary is disclosed by the contract" because "contracting parties are presumed to contract in reference to the existing law; indeed, they are presumed to have in mind all the existing laws relating to the contract." *Poole & Kent Corp. v. C. E. Thurston & Sons, Inc.*, 209 S.E.2d 450, 455 (N.C. 1974). Thus, in a case like this, where the parties make no express, alternative allocation, the parties are deemed by operation of North Carolina law to have accepted the default allocation set forth in the statute. That completely resolves any tension that might otherwise be perceived with *Ahlborn*, because it means that a settlement like the one at issue here, as a matter of law, allocates one-third of the recovery to cover the State's medical expenses.

B. North Carolina is more generous to Medicaid recipients than private insurers

North Carolina's law is also a reasonable exercise of the State's discretion because it leaves Medicaid recipients in a considerably better position than many private insurers would allow. In the private insurance context, one of the standard rules that apply where the insured is not fully reimbursed for a

loss caused by a tortfeasor is the "insurer-first" rule, in which the insurer is first made whole out of any recovery from a third party, and the insured takes the balance. *See* ROBERT E. KEETON & ALAN A. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES AND COMMERCIAL PRACTICES § 3.10(b)(1) (1988).

This Court recently allowed a health insurer sponsor to pursue "insurer-first" recovery from a tort victim in the ERISA context. *See Sereboff v. Mid-Atlantic Medical Services, Inc.*, 547 U. S. 356 (2006). And while some States disapprove "insurer-first" recovery, several States allow it and it is common for private insurers to require it in those States. *See, e.g., North Buckeye Education Council Group Health Benefits Plan v. Lawson*, 814 N.E.2d 1210 (Ohio 2004); *Trogub v. Robinson*, 853 N.E.2d 59 (Ill. App. Ct. 2006); *see also Met Life Auto & Home Insurance Co. v. Lester*, 719 N.W.2d 385 (S.D. 2006) (allowing "insurer-first" recovery under a property insurance contract).

North Carolina's statute is substantially more generous to Medicaid recipients than the "insurer-first" regime. First, it allows a Medicaid recipient to make a good faith allocation to avoid the one-third maximum apportionment otherwise imposed by the statute. Second, it guarantees a Medicaid recipient will receive at least two-thirds out of any tort settlement, regardless of what the State has paid for medical expenses. North Carolina's statutory scheme thus reflects a reasonable, and indeed generous, approach to recovery by the State-as-insurer, one that many private insurers would eschew.

C. This Court should approve North Carolina's statute in light of the administering agency's approval

In short, North Carolina's statute provides a reasonable, efficient solution to a difficult problem. It allows the State to recoup costs, while not only giving the parties complete power to negotiate around the default rules, but also promising a substantial recovery for Medicaid recipients in every case in which they do not stipulate to an allocation. Additionally, the North Carolina statute and the decision in *Andrews*, holding that North Carolina's statute is consistent with *Ahlborn*, have already been analyzed and approved by the Centers for Medicare & Medicaid Services (CMS), "[t]he federal agency in charge of administering Medicaid." *Douglas v. Independent Living Center of Southern California Inc.*, 132 S. Ct. 1204, 1207 (2012). This Court should approve North Carolina's statute in light of that agency approval.

After *Ahlborn*, CMS opined on what actions a State could take to ensure recovery from tortfeasors while remaining consistent with the Court's decision. In its memorandum, the agency noted that "State tort or insurance liability provisions are a matter of State law and could be utilized to mitigate the adverse affects of the decision," and advised that, consistent with *Ahlborn*, "a State can enact laws which provide for a specific allocation amongst damage[s], *i.e.*, pain and suffering, lost wages, and medical claims." Pet. App. 129a. The North Carolina statute here, as construed by *Andrews*, does exactly that in the limited context where the parties have declined to agree on an allocation. CMS's generally stated views support approval of the North Carolina regime.

CMS then specifically considered and approved North Carolina's statute. CMS noted that this Court in *Ahlborn* "did not mandate a specific method for determining the medical expense portion of a plaintiff's settlement," and expressed its view that "States have leeway to develop a reasonable statutory scheme for apportioning medical expenses." Pet. App. 141a. The agency stated that CMS "agree[s] with the decision" of the North Carolina Supreme Court in *Andrews*, and expressed the view that both the *Andrews* decision and the State's attempt to recover in *Andrews* were not in "conflict with CMS['s] guidance." Pet. App. 142a.

Where CMS has considered and approved a state statute implementing Medicaid, this Court should defer to the agency's view. First, as noted, this Court has "not been reluctant to leave a range of permissible choices to the States, at least where the superintending federal agency has concluded that such latitude is consistent with the statute's aims." *Blumer*, 534 U. S. at 495. Here the administering agency has indeed specifically concluded that "States have leeway to develop a reasonable statutory scheme for apportioning medical expenses." Pet. App. 141a. This Court should leave open the States' options for recovering, consistent with the agency's view that the States should have that "leeway."

Second, this Court should defer to the agency's reliance upon the decision in *Andrews*. This Court recently reiterated the importance of deferring to CMS's opinion on state statutes implementing Medicaid where "the agency is comparatively expert in the statute's subject matter" and "the agency's expertise is relevant in determining [the statute's] application." *Douglas*, 132 S. Ct. at 1210 ("review of agency action

requires courts to apply certain standards of deference to agency decisionmaking") (citing *National Cable & Telecommunications Association v. Brand X Internet Services*, 545 U. S. 967 (2005) and *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837 (1984)). *Id.* In *Douglas*, the Court remanded following CMS's announcement of its support for a number of state statutes, finding that CMS's new approval of the statutes might change the plaintiffs' ability to challenge them. *Id.* Here, where CMS has considered the validity of North Carolina's statute in balancing federal requirements, state needs, and citizens' rights, the Court should respect that determination and similarly uphold the statute.

CONCLUSION

The decision of the Fourth Circuit should be reversed.

Respectfully submitted,

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AMICUS CURIAE BRIEF

RECORD
AND
BRIEFS

No. 12-98

In the Supreme Court of the United States

ALBERT A. DELIA, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

E.M.A., A MINOR, BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON, WILLIAM EARL ARMSTRONG, AND SANDRA ARMSTRONG,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF TEXAS, ALABAMA, GEORGIA, HAWAII, IDAHO, INDIANA, MICHIGAN, NEBRASKA, NEW MEXICO, OHIO AND SOUTH CAROLINA AS AMICI CURIAE IN SUPPORT OF PETITIONER

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INTEREST OF AMICI

Medicaid expenditures consume large portions of every State's budget. The amici curiae have an interest in mitigating the costs associated with administering their Medicaid programs, and in strengthening the federalism-protecting interpretive canons that should apply whenever a court interprets the federal Medicaid Act.

STATEMENT

In *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006), this Court held that the federal Medicaid Act precludes a participating State from imposing a lien on a beneficiary's property, except to the extent that the State seeks to recover its Medicaid expenditures from damages that the beneficiary obtains for medical expenses from a third-party tortfeasor. *See id.* at 284-285. But many times a jury verdict or settlement agreement will award the beneficiary a lump sum, without marking any portion of the damages as compensation for medical expenses. North Carolina law therefore requires the Medicaid beneficiary to designate up to one-third of her tort recovery as compensation for medical expenses, which must be used to reimburse the State for the medical expenditures it made on the beneficiary's behalf. Without this statutory allocation, the parties to a settlement could eliminate the State's subrogation rights by designating the entire award as compensation for pain and suffering, while leaving nothing for medical expenses.

Respondent E.M.A. entered into a settlement agreement for a lump-sum payment, which was not allocated among different categories of damages. The State of North Carolina imposed a lien against one-third of E.M.A.'s recovery, consistent with the statutory allocation that deems one-third of a Medicaid beneficiary's tort recovery to represent

compensation for medical expenses. The issue in this case is whether the relevant North Carolina statutes are "preempted" by the federal Medicaid Act as construed in *Ahlborn*. The Fourth Circuit held that North Carolina's statutory allocation is preempted, and that the State must provide individualized hearings to determine the "true value" of the medical-expenses portion of E.M.A.'s settlement. This Court granted certiorari.

SUMMARY OF ARGUMENT

The Fourth Circuit erred by holding that North Carolina's statutory provisions are "preempted" by the Medicaid Act, at least as applied to the situation in this case.

First, any conditions on the receipt of federal funds must be set out "unambiguously," and recipients of federal funds must accept them "voluntarily and knowingly." *See Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981); *see also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2602 (2012) (opinion of Roberts, C.J.). The federal Medicaid Act, however, is silent on how States should determine the amount of a beneficiary's tort recovery that represents compensation for medical expenses—especially in cases such as this one, where the parties entered into a lump-sum settlement without agreeing on an allocation among the

different categories of injury. Nothing in the Medicaid Act precludes States from determining the amount of compensation for medical expenses through a statutory formula, rather than a contextualized individual hearing. And there is certainly no "unambiguous" language to this effect in the federal statutory provisions or regulatory guidance. The court of appeals therefore erred by imposing its "true-value hearing" solution over the statutory allocation adopted by the State of North Carolina.

Second, even if North Carolina's law is inconsistent with the provisions of the Medicaid Act, the court of appeals erred by holding the state law "preempted." The federal Medicaid Act does not require that a State choose between withdrawing from Medicaid and complying with every provision of the Medicaid Act. 42 U.S.C. § 1396c gives the Secretary of Health and Human Services discretion to withhold only a *portion* of federal Medicaid reimbursement from a non-compliant State, and States may—without violating *any* federal law—choose to accept this reduction in federal funding while remaining participants in the federal Medicaid program. A State law cannot be deemed "preempted" by a federal statute that does nothing more than specify criteria for federal reimbursement.

Unlike statutes such as Title VI and the Religious Land Use and Institutionalized Persons Act, the Medicaid Act does not impose forward-

looking obligations on States that accept federal Medicaid reimbursements; it merely dangles a carrot in front of the States by promising federal reimbursement to those that comply with the Medicaid Act's guidelines. A State does not violate federal law by failing to take the federal government up on this offer, and it does not violate federal law by acting in a manner that may provoke the Secretary of Health and Human Services into reducing or eliminating the state's Medicaid allotment. *See, e.g.*, *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2607.

ARGUMENT

I. THE FOURTH CIRCUIT ERRED BY FAILING TO APPLY THE CLEAR-STATEMENT REQUIREMENT OF *PENNHURST*.

The federal Medicaid Act is spending legislation; it offers to reimburse States for the expenses of their Medicaid programs so long as those state programs comport with federal guidelines. *See* 42 U.S.C. § 1396a (establishing criteria for state Medicaid programs); *id.* § 1396b (providing reimbursement to the States for most of their Medicaid-related expenditures). If the Secretary of Health of Human Services determines that a State's Medicaid program does not comport with the criteria for reimbursement established in § 1396a, he must decide whether to withhold *all* federal reimbursement from that State's Medicaid program, or withhold funding only from those *parts* of the State Medicaid plan that do not

comport with 42 U.S.C. § 1396a. *See id.* § 1396c ("[T]he Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply.").

Because the Medicaid Act is federal spending legislation, the clear-statement rule of *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), applies. This Court has long held that conditions on the receipt of federal funds must be set out "unambiguously," and that recipients of federal funds must accept those conditions "voluntarily and knowingly." *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (quoting *Pennhurst*, 451 U.S. at 17). But the Fourth Circuit never cited *Pennhurst* and never considered how its clear-statement requirement should inform the analysis in this case. Had the Fourth Circuit viewed the provisions in the Medicaid Act through the lens of *Pennhurst*, it would have been compelled to uphold the North Carolina statutes, at least as applied to the situation in this case.

The Medicaid Act withholds federal funding if a State imposes a lien against the "property of any

individual" on account of medical assistance paid under a state Medicaid plan. 42 U.S.C. § 1396p(a).[1] Yet it simultaneously instructs participating States to "seek reimbursement" for the medical expenses they have paid whenever a Medicaid beneficiary recovers damages from a tortfeasor who caused her medical bills. *Id.* § 1396a(a)(25)(B). Specifically, the Medicaid Act instructs Medicaid-participating States to enact

> laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.

Id. § 1396a(a)(25)(H). And every state Medicaid plan must, if it wishes to receive federal reimbursement, require Medicaid beneficiaries

> to assign the State any rights . . . to support (specified as support for the purpose of medical care by a court or

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[1] The anti-lien provision in the Medicaid Act is subject to exceptions, but they are not applicable here. *See* 42 U.S.C. § 1396p(a)(1)(A)–(B).

> administrative order) and to payment for medical care from any third party.

Id. § 1396k(a)(1)(A).

Taken together, these statutory provisions unambiguously preclude a state Medicaid plan from imposing a lien against an individual's "property," except for damages that the beneficiary has recovered for medical expenses from a third-party tortfeasor. *See Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 284-285 (2006). A Medicaid-participating State—if it wishes to receive full federal funding—cannot impose a lien against a beneficiary's recovery for lost income, pain and suffering, punitive damages, or anything other than medical expenses. As this Court explained in *Ahlborn*:

> To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. . . . But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care.

> Beyond that, the anti-lien provision applies.

Id.

This rule is easy to apply when the beneficiary and the State have stipulated that a specific portion of an award or settlement represents payment for medical expenses. *See, e.g., Ahlborn*, 547 U.S. at 288 (noting that the state agency and the Medicaid beneficiary had stipulated that $35,581.37 of the beneficiary's settlement was "designated as payments for medical costs").

But matters become more complicated when a jury verdict or settlement agreement awards the plaintiff a lump sum without parceling the money into discrete categories of damages, or when parties to a settlement agreement attempt to thwart the State's rightful recovery by minimizing the amount allocated to medical expenses. In these situations, the State is not only entitled but *required* to recover the portion of the award that compensates the Medicaid beneficiary for medical expenses. *See* 42 U.S.C. §§ 1396a(a)(25)(B), 1396a(a)(25)(H), 1396k(a)(1)(A); *Ahlborn*, 547 U.S. at 282 ("[T]he federal third-party liability provisions *require* an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care.") (emphasis in original). Yet the true amount of the compensation for medical expenses is unknown and *cannot* be known. A jury that awards

compensatory damages without designating a specific portion for medical expenses cannot be reconstituted and questioned when the State seeks to recover its rightful share of the award. And when parties enter into a settlement agreement, it is impossible for the State (or anyone else) to prove that a specific amount constitutes compensation to the plaintiff for medical expenses. Finally, if the parties to a settlement try to limit the State by allocating little or nothing to medical expenses, then the State cannot recover its expenses if it is bound by the artificially low amount designated for medical expenses in the settlement agreement.

Although the federal Medicaid Act draws a clear and unambiguous distinction between damages that a beneficiary recovers for medical expenses, which are exempt from § 1396p(a)'s anti-lien provision, and damages recovered for other types of injuries, the Medicaid Act is silent on *how a State should determine* the amount of a jury award or settlement that represents compensation for medical expenses. An approach that allows the State to recover only funds that are specifically designated as damages for medical expenses in the jury verdict or settlement agreement is not acceptable, because many times the verdict or settlement will fail to allocate the award among the different categories of injuries, and settlement agreements can be manipulated by the parties to minimize or eliminate the amount of damages earmarked for medical expenses. *See*

Ahlborn, 547 U.S. at 288 (recognizing this danger). Indeed, the parties to a settlement have a shared incentive to minimize or zero out the amount allocated to medical expenses, as money allocated to medical expenses is worthless to the victim (because it will be taken by the State), and the tortfeasor doesn't care where the money goes once it leaves his pockets. In light of this obvious problem, a State deciding whether to accept federal Medicaid dollars would reasonably assume that the federal anti-lien provision would not deprive the States of the power to protect themselves from these types of manipulated settlement agreements. Far from containing a clear statement that the States *can't* enact legislation of the sort that North Carolina has adopted, the provisions of the Medicaid Act requiring participating States to recoup their medical expenditures from a beneficiary's tort recovery point in the opposite direction. Every Medicaid-participating State must establish some kind of mechanism for determining the amount of an award or settlement that is properly attributed to medical expenses.

There are many possible approaches available to the States. All of them present tradeoffs between decision costs and error costs. And each is consistent with the federal Medicaid Act—especially when the Act is construed (as it must be) in light of *Pennhurst*'s clear-statement requirement.

One possibility is for a State to hold a trial-like adversarial proceeding to determine the amount that a jury or parties to a settlement "intended" to award for medical expenses, or that represents a "fair" allocation to medical expenses. This approach might be thought to pursue the maximum possible accuracy in determining the amount properly allocated to medical expenses. But it imposes significant decision costs by requiring an adversarial hearing whenever the State seeks to recover its Medicaid expenditures from a beneficiary's tort recovery. *See* Pet. Br. 15 (noting these hearings "will entail presentation of liability and damage evidence from experts, imposing significant litigation costs and burdens on both the recipient and the State"). And it is far from clear that incurring these added decision costs will produce much in the way of improved accuracy. Rough cuts and approximations are unavoidable in these situations, and a regime that resolves each of these disputes through a case-by-case adversarial process will open the door to arbitrary and inconsistent decisionmaking. *See* Antonin Scalia, *The Rule of Law as a Law of Rules*, 56 U. CHI. L. REV. 1175 (1989) (showing how rules provide the benefits of "predicatability" and the "appearance of equal treatment," and how case-by-case discretion undermines these values).

Another possibility is to establish a statutory formula that designates one-third of a beneficiary's tort recovery (or some other fraction) as

compensation for medical expenses—even when the jury verdict or settlement agreement specifies a different amount. *See, e.g.*, N.C. GEN. STAT. § 108A-57. This approach has the advantage of providing an easy-to-apply rule that obviates the need for a hearing, and it prevents litigants from structuring settlement agreements that minimize the State's recovery by allocating an artificially low amount toward medical expenses. And by avoiding a regime of individualized hearings, it reduces the risk of arbitrary or inconsistent treatment among similarly situated beneficiaries.

Hybrid approaches are also available. A State might, for example, establish a *rebuttable* presumption that deems a fraction of a beneficiary's tort recovery compensation for medical expenses, while allowing the beneficiary to overcome this presumption with a preponderance of the evidence (or with clear and convincing evidence). The court of appeals thought that the Medicaid Act required North Carolina to adopt this type of regime, and precluded the State from *ever* treating as conclusive the statutory allocation established in N.C. GEN. STAT. § 108A-57. *See E.M.A v. Cansler*, 674 F.3d 290, 312 (4th Cir. 2012) ("[T]he sum certain allocable to medical expenses must be determined by way of a fair and impartial adversarial procedure that affords the Medicaid beneficiary an opportunity to rebut the statutory presumption . . . ."). As the court of appeals saw matters, an adversarial hearing is

required in *every* case in which the beneficiary wants to dispute the statutory provision that defines one-third of a tort recovery as damages for medical expenses. *Id.*

Another hybrid approach would establish an irrebuttable statutory presumption but exempt certain categories of cases from that presumption, such as: (1) cases in which a jury verdict specifically allocates the beneficiary's recovery between medical and non-medical expenses, and (2) cases in which the beneficiary and state agency stipulate that a certain portion of an award or settlement agreement represents compensation for medical expenses. In these two categories of cases, the "true" amount of recovery for medical expenses can be easily ascertained, so there is no need to resort to statutory allocations. In all other cases, the recovery for medical expenses will be one-third of the jury's award or settlement proceeds, because an effort to determine the "real" amount of recovery for medical expenses in these situations is likely to become a snipe hunt.

The court of appeals went off track by requiring an adversarial proceeding in *every* case in which the State and the beneficiary disagree over the amount that should be deemed recovery for medical expenses. And the court of appeals especially erred by requiring a hearing on the facts of this case, where the Medicaid beneficiary agreed to a lump-sum settlement that makes no allocation between

the funds recovered for medical expenses and those recovered for other injuries. The court of appeals's approach would be more understandable if it were possible to dissect a lump-sum tort recovery into payments to compensate the plaintiff for medical expenses and those for other purposes. But there is no non-arbitrary way to determine which part of these settlement proceeds represents the "true" payment for medical expenses—even after conducting a "fair and impartial adversarial procedure." *Cansler*, 674 F.3d at 312. It cannot be said that the Medicaid Act forbids North Carolina's resort to rule-based statutory allocations—at least in cases (such as this one) in which the beneficiary receives a lump-sum recovery from a settlement agreement.

The court of appeals's mistake was its tacit assumption that lump-sum settlement awards comprise discrete portions that were designed to compensate the beneficiary for medical expenses, and its further assumption that it is possible to ascertain the amount of money in this "medical expenses" portion through the mechanism of an adversary hearing. But there *is no way to determine* what portion of a lump-sum settlement represents the "true" amount of compensation for medical expenses. A judge or arbitrator will inevitably have to resort to decisionmaking shortcuts, such as rules of thumb, approximations, or outright guesses. It is simply not possible to eliminate (or even reduce)

error costs by insisting on a "fair and impartial adversarial procedure." And in this case, it is hard to see how the outcome of an adversarial hearing could be any more accurate than the result mandated by the North Carolina statutes. In all events, the federal Medicaid Act does not require adversarial hearings to determine the amount of a tort recovery that should be allocated toward medical expenses, and it certainly does not contain the "unambiguous[]" language on this point that would be needed to satisfy the requirements of *Pennhurst*.

The court of appeals was troubled by the possibility that a State might establish an unreasonably high percentage of a beneficiary's tort recovery as compensation for medical expenses. *See Cansler*, 674 F.3d at 311 ("[N]othing would prevent states from allocating 75%, 90% or even 100% of a settlement to medical expenses, thereby eviscerating the rule promulgated by *Ahlborn*."). The court of appeals was mistaken, however, to suggest that a ruling upholding the North Carolina statute would open the door to such regimes. A statutory allocation will be valid only if it supplies a plausible rule-of-thumb for determining the proportion of a tort recovery that should be deemed to represent compensation for medical expenses; otherwise it will contravene the construction of the anti-lien provision that this Court adopted in *Ahlborn*. North Carolina's regime undoubtedly passes muster under this standard. The court of appeals committed a slippery-

slope fallacy by denying that any principled distinction can be drawn between the North Carolina statutes and the hypothetical regimes described in its opinion. *See* Eugene Volokh, *The Mechanisms of the Slippery Slope*, 116 HARV. L. REV. 1026 (2003).

The Medicaid Act is silent on how States should determine the amount of a beneficiary's tort recovery that represents compensation for medical expenses—especially in cases such as this one, where the parties entered into a lump-sum settlement without ever agreeing on an allocation among the different categories of injury. *Any* approach to determining the portion of a lump-sum tort recovery that represents compensation for medical expenses will produce imprecision and guesswork. How to deal with these imprecisions, and how to calibrate the tradeoffs between decision costs and error costs, are decisions left to the States that must administer the Medicaid programs. The Medicaid Act does not require adversarial hearings to determine the amount of a tort recovery that should be allocated toward medical expenses, and it certainly does not contain the "unambiguous[]" language needed to satisfy the requirements of *Pennhurst*. The court of appeals erred by imposing its "true-value hearing" solution over the rule-based statutory allocation adopted by the State of North Carolina.

II. THE MEDICAID ACT IS INCAPABLE OF "PREEMPTING" STATE LAW, BECAUSE A STATE DOES NOT VIOLATE FEDERAL LAW MERELY BY ACTING IN A MANNER THAT REQUIRES FEDERAL MONEY TO BE WITHHELD.

There is a more fundamental problem with the court of appeals's opinion: A State law cannot be deemed "preempted" by a federal statute that does nothing more than specify criteria for federal reimbursement.

Some types of federal spending legislation, such as Title VI of the Civil Rights Act of 1964 and the Religious Land Use and Institutionalized Persons Act (RLUIPA), impose binding legal obligations on entities that accept federal funds. These statutes require any "program or activity receiving Federal financial assistance" to accommodate religious liberties and refrain from racial discrimination. *See* 42 U.S.C. § 2000d ("No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."); 42 U.S.C. § 2000cc(a)(2)(A) (requiring any "program or activity that receives Federal financial assistance" to accommodate religious liberties). Under these laws, entities must renounce or return federal aid *before* deviating from the specified conditions; otherwise they become federal lawbreakers if they violate the conditions imposed on

the receipt of federal funds. *See Cannon v. Univ. of Chi.*, 441 U.S. 677 (1979) (allowing private individuals to sue for injunctive relief against entities that accept federal money yet fail to comply with Title IX, which prohibits sex discrimination by universities receiving federal financial assistance).

Other types of federal spending legislation merely offer annual reimbursement to States that comply with certain conditions, or threaten to withhold federal funds from noncompliant States. One example is the statute relating to the 21-year-old drinking age. It states that

> [t]he Secretary shall withhold 10 per centum of the amount required to be apportioned to any State under each of sections 104(b)(1), 104(b)(3), and 104(b)(4) of this title on the first day of each fiscal year after the second fiscal year beginning after September 30, 1985, in which the purchase or public possession in such State of any alcoholic beverage by a person who is less than twenty-one years of age is lawful.

23 U.S.C. § 158 (a)(1)(A). Under this type of spending legislation, a State retains the prerogative to lower its drinking age to 18 even after accepting federal highway money. It may lose some future federal money as a consequence of that decision, but it is not breaking any federal law by deviating from criteria for reimbursement and provoking the

Secretary of Transportation to reduce the State's allocation of federal funds. No one would contend that a State is violating federal law by returning to an 18-year-old drinking age—even after accepting federal highway funds—and no one could maintain a "preemption" lawsuit if a State were to do so.

The Medicaid Act falls within the latter category of spending legislation. State laws cannot be "preempted" by the Medicaid Act because this statute does not obligate the States to do *anything*—even after a State receives reimbursement from the federal government for its Medicaid program. The Medicaid Act permits States to administer their Medicaid programs as they please; it merely requires the Secretary of Health and Human Services to reimburse States whose Medicaid programs satisfy the criteria specified in § 1396a. A State retains the lawful prerogative to establish a Medicaid program that deviates from § 1396a at any time, and then wait to see if the Secretary will turn off the spigot or merely reduce the amount of federal funding. There is *nothing unlawful* about state officials taking actions that might goad the Secretary into halting some or all of the State's Medicaid reimbursement payments. *See Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2607 (holding that States may choose to violate conditions in the Affordable Care Act and accept a reduction in federal Medicaid reimbursement). A State that departs from the Medicaid Act's reimbursement criteria does not even violate federal

law, let alone deprive any person of federally protected "rights" under 42 U.S.C. § 1983.

All of this becomes evident when one reads 42 U.S.C. § 1396c, which provides:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—
>
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

42 U.S.C. § 1396c. Nothing in this statute, or any other provision of the Medicaid Act, imposes forward-looking obligations on States that accept federal Medicaid reimbursements. The Medicaid Act does not reflect the approach of Title VI or RLUIPA; nowhere does the Medicaid Act say anything akin to: "No State that receives federal Medicaid funds shall . . . ." The Medicaid Act does nothing more than dangle a carrot in front of the States: If you administer a Medicaid program that satisfies the criteria of § 1396a, then the federal government will reward you by reimbursing some of your expenditures. A State does not violate federal law by failing to meet the terms of the federal government's offer, and a state statute cannot be deemed "preempted" by a federal statute that does nothing more than specify criteria for federal reimbursement.

So even if the Fourth Circuit were correct to conclude that North Carolina's statute fails to comport with provisions in the federal Medicaid Act, it erred by holding the statute "preempted." If the Fourth Circuit's interpretation of the Medicaid Act is correct, then North Carolina is no different from a State that lowers its drinking age below 21. It may have acted in a manner that will cause it to lose federal funding in the future, but it has not violated any legal obligation imposed by Medicaid Act or any other provision of federal law. If the Secretary of Health and Human Services decides that North Carolina's statute merits only a *partial* reduction in

federal funding under 42 U.S.C. § 1396c, North Carolina might choose to accept this partial reduction in federal funding rather than abandon the statutory allocation in N.C. GEN. STAT. § 108A-57. The Fourth Circuit's ruling robs North Carolina of the opportunity to make this perfectly lawful choice.[2]

CONCLUSION

The judgment of the Court of Appeals should be reversed.

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[2] In *Ahlborn*, the State of Arkansas never questioned whether private litigants could assert "preemption" claims under the Medicaid Act. Arkansas staked its entire case on its claim that its statutes complied with the Medicaid Act's anti-lien provision. *See* Brief for the Petitioners, *Ahlborn*, (No. 04-1506), 2005 WL 3156905. *Ahlborn* therefore cannot establish a precedential holding that the Medicaid Act is capable of preempting state law, or that private litigants may assert preemption claims whenever a State deviates from the Medicaid Act's criteria for reimbursement. *See Brecht v. Abrahamson*, 507 U.S. 619, 630-631 (1993), *superseded by statute on other grounds*, AEDPA, 28 U.S.C. § 2254(d) ("[S]ince we have never squarely addressed the issue, and have at most assumed [an answer], we are free to address the issue on the merits."); *Waters v. Churchill*, 511 U.S. 661, 678 (1994) (plurality opinion) ("These cases cannot be read as foreclosing an argument that they never dealt with."); *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 557 (2001) (Scalia, J., dissenting) ("Judicial decisions do not stand as binding 'precedent' for points that were not raised, not argued, and hence not analyzed.").

Respectfully submitted.

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APPENDIX
STATUTES INVOLVED

N.C. GEN. STAT. § 108A-57 ..... 1a

N.C. GEN. STAT. § 108A-59 ..... 3a

42 U.S.C. § 1396a(a)(18) (2006) 5a

42 U.S.C. § 1396a(a)(25)(H) (2006) 6a

42 U.S.C. § 1396c (2006) 7a

42 U.S.C. § 1396k (2006) 8a

42 U.S.C. § 1396p (2006) 11a

STATUTES INVOLVED

North Carolina General Statute § 108A-57

Subrogation rights; withholding of information a misdemeanor

(a) Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance, or of the beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person. The county attorney, or an attorney retained by the county or the State or both, or an attorney retained by the beneficiary of the assistance if this attorney has actual notice of payments made under this Part shall enforce this section. Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.

The United States and the State of North Carolina shall be entitled to shares in each net recovery under this section. Their shares shall be promptly paid

under this section and their proportionate parts of such sum shall be determined in accordance with the matching formulas in use during the period for which assistance was paid to the recipient.

(b) It is a Class 1 misdemeanor for any person seeking or having obtained assistance under this Part for himself or another to willfully fail to disclose to the county department of social services or its attorney the identity of any person or organization against whom the recipient of assistance has a right of recovery, contractual or otherwise.

(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article.

North Carolina General Statute § 108A-59

Acceptance of medical assistance constitutes assignment to the State of right to third party benefits; recovery procedure

(a) Notwithstanding any other provisions of the law, by accepting medical assistance, the recipient shall be deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise, to which he may be entitled.

It shall be the responsibility of the county attorney of the county from which the medical assistance benefits are received or an attorney retained by that county and/or the State to enforce this subsection, and said attorney shall be compensated for his services in accordance with the attorneys' fee arrangements approved by the Department of Health and Human Services.

(b) The responsible State agency will establish a third party resources collection unit that is adequate to assure maximum collection of third party resources.

(c) Notwithstanding any other law to the contrary, in all actions brought pursuant to subsection (a) of this section to obtain reimbursement for payments for medical services, liability shall be determined on the basis of the same laws and standards, including bases for liability and applicable defenses, as would be applicable if the action were brought by the

individual on whose behalf the medical services were rendered.

42 U.S.C. § 1396a(a)(18) (2006)

§ 1396a. State plans for medical assistance

(a) Contents
A State plan for medical assistance must—

* * * *

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid,[,] transfers of assets, and treatment of certain trusts;

* * * *

42 U.S.C. § 1396a(a)(25)(H) (2006)

A State plan for medical assistance must—

* * * *

(25) provide—

* * * *

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

* * * *

42 U.S.C. § 1396c (2006)

Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

42 U.S.C. § 1396k (2006)

Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—

> (1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—
>
> > (A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter [42 USC §§ 1396 et seq.] and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1396a(l)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396p (2006)

Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan[.]

* * * *